CONFUSED ABOUT THE NEW MEDICARE LCD?

The Illinois Chiropractic Society is continually working to ensure our members have the latest information. As we announced last month, National Government Services (NGS) modified the chiropractic Local Carrier Determination (LCD) for our region, and the changes that NGS implemented are very positive for our profession.

We are receiving information from members that indicates there is some confusion surrounding the removal of the secondary diagnosis codes from the LCD. The ICS has spoken to our national liaisons and with NGS directly regarding these changes, and we have confirmed the information we previously issued and the information below.

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ARE CHIROPRACTIC PHYSICIANS ABLE TO OPT-OUT OF MEDICARE?

The answer typically seems easy – No. Chiropractic Physicians are not allowed to opt-out of Medicare.

However, in an attempt to avoid the regulations, billing requirements, and documentation requirements, some chiropractic physicians attempt to find the loopholes in this prohibition. In short, the only way to avoid Medicare requirements is to not see a Medicare eligible patient.

Medicare has released a number of documents that clearly demonstrate that there is no way to avoid Medicare regulations and contract with a Medicare eligible patient other than opting out; and chiropractors are not allowed to opt-out. Here is the short explanation:

1. Medicare requires physicians to submit claims for all covered services within one year from date of service (a few exceptions are listed below);
2. “Acute, chronic, and maintenance adjustments are all ‘covered’ services.”
3. Medicare requires that an ABN be obtained from a patient when rendering a covered service you feel will be denied;

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PHYSICIAN OFFICE AS SMALL BUSINESS: EMPLOYER OBLIGATIONS UNDER THE AFFORDABLE CARE ACT

A health care practice is both profession and business. In addition to providing professional resources, the ICS keeps physicians aware of employment laws and regulations that apply to the physician office as an employer.

Almost everybody is aware of the Patient Protection and Affordable Care Act (PPACA) and its creation of a health plan marketplace for individuals. What is less understood is the law’s impact on employers. As a business entity with employees, a physician practice owner needs to be familiar with requirements regarding health coverage and the applicability of other mandates or penalties.

The requirements of PPACA vary based on the size of the employer. Because most ICS members are small employers (defined as businesses with fewer than 25 full time employees), this article will highlight some of the basic PPACA provisions that apply to small employers. Although the requirements are more stringent for larger employers (50 or more employees), a number of important mandates apply to small employers as well.

Are Employers Required to Provide Insurance?
The “Employer Shared Responsibility Provision” refers to the portion of the PPACA regarding whether employers must provide health coverage to their employees. Businesses with fewer than 50 full time (30 hours of service per week) employees are not required to pay for or provide health insurance to their employees, and these businesses will not be required to pay a tax penalty for not providing health insurance. Therefore, most chiropractic offices are not required to provide health insurance under the PPACA.

Waiting Periods: Employers Who Provide Health Insurance
Though not required, many employers offer to provide health insurance as a benefit of employment. One important provision pertains to the “waiting period” during which the employee is not eligible for coverage when starting employment. Before the PPACA, it was not uncommon for employers to impose waiting periods of up to 6 months. Under the new law, the employer...Continued on Page 2
cannot impose a waiting period longer than 90 calendar days from the employee’s eligibility date (usually the employee’s hire date). Of course, employers may opt for a shorter waiting period, or none at all.

**Required Employee Notice of Exchanges and Insurance Options**

The PPACA requires employers, including small employers (even those with one employee), to notify employees of their health care options. Most importantly, employers must post a notice regarding the health insurance exchange. Additionally, employers who offer health insurance must provide employees with a Summary of Benefits and Coverage:

- **Employee Notice of Exchange** – This notice must be posted by all employers who are subject to the Fair Labor Standards Act (FLSA), which covers most employers. (For more details about whether the FLSA covers a particular employer, see the Department of Labor’s website at: http://webapps.dol.gov/elaws/whd/flsa/sc010.asp.) Employers must provide all employees, within 14 days of an employee’s start date, with written notice about the PPACA health insurance Exchanges.

  In general, the notice must: (1) include information regarding the existence of an Exchange, as well as contact information and a description of services provided by an Exchange; (2) explain that employees may be eligible for a premium tax credit or a cost-sharing reduction if the employee purchases a qualified health plan through the Exchange; and (3) inform employees that, if they purchase coverage through the Exchange, they may lose any employer contribution toward the cost of employer-provided coverage, and that all or a portion of this employer contribution may be excludable for federal income tax purposes.

  The United States Department of Labor (DOL) has provided two model Exchange Notices for employers: a model Exchange notice for employers who do not offer a health plan, and a model Exchange notice for employers who offer a health plan to some or all employees. Both model Exchange notices may be downloaded from the DOL website at: http://www.dol.gov/ebsa/healthreform/regulations/coverageoptionsnotice.html

- **Summary of Benefits and Coverage (SBC)** – Employers who offer health plans Group health plans must give employees an SBC that accurately describes the benefits and coverage under the applicable plan or coverage. PPACA regulations require that the SBC be provided in several instances (upon application, by the first day of coverage if there are any changes, special enrollees, upon renewal, upon request and off-renewal changes).

  The Department of Labor has provided a sample completed SBC that employers may view at: http://www.dol.gov/ebsa/pdf/CorrectedSampleCompletedSBC2.pdf.

**Limits on Flexible Spending Account Contributions**

For employers who offer Flexible Spending Accounts, as of January 2013, the maximum amount an employee may elect to contribute to health care flexible spending arrangements (health FSAs) for any year will be capped at $2,500, subject to cost-of-living adjustments. The limit only applies to elective employee contributions and does not extend to employer contributions. To learn more about FSA Contributions, as well as what is excluded from the cap, visit IRS.gov.

**Small Business Health Care Tax Credit**

Small businesses that offer to provide health insurance to employees may be eligible for a tax refund called a “small business health care tax credit.” If a physician office employs fewer than 25 employees, pays at least half of employees’ healthcare premiums for health insurance for its employees, and average salaries for employees are less than $50,000 per year, the nonprofit can apply for a “small employer health care tax credit” that is intended to help defray the cost of health insurance for employees. The Small Business Administration provides more detailed information about how to
Medicare LCD... CONTINUED

Important: The elimination of the secondary codes was not a mistake nor a result of any confusion. This was an intentional change that was negotiated by American Chiropractic Association representatives with NGS and CMS. This elimination was a big step forward towards parity for chiropractic physicians, as you can now utilize the correct ICD-10 code that most closely resembles the diagnosis demonstrated. There is no longer a restrictive list for secondary/qualifying diagnosis codes.

Here are some particulars for your Medicare billing practices based on the new LCD:

1. “The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation.” Therefore, the primary diagnosis must indicate subluxation, and chiropractic physicians must use Group 1 Codes as indicated in the LCD (M99.01-M99.05). This is not new and has been a requirement under the law for many decades.

2. There is no longer a specific listing of secondary (Group 2 Codes) within the LCD (All 263 code references have been removed). The result of the removal of the secondary diagnosis listing from the LCD means that our doctors can utilize the correct ICD-10 code that most closely resembles the diagnosis demonstrated.

3. Although a secondary (and additional) diagnosis code is not mandatory, The Illinois Chiropractic Society strongly urges chiropractic physicians to include any relevant secondary/qualifying diagnosis to properly reflect the patient’s condition, correctly code the documented diagnosis, protect against potential future claims reviews, and clearly demonstrate the number of conditions that we treat as a profession. As we continually aim for provider parity within Medicare, we must document and bill at the highest level. This includes documenting and billing qualifying/secondary diagnosis codes.

Please watch for more ICS releases about a continued national effort to create parity within Medicare, including treatment coverages, opt-in/opt-out laws, and within LCDs nationwide.

Affordable... CONTINUED

calculate the tax credit and about other health care benefit options for small employers at: https://www.sba.gov/content/employers-with-fewer-25-employees.

Steps to Take Now and Additional Resources for Small Businesses

The enactment of any new law affecting employment can impact physician offices as well as any other small business. This article has highlighted a few of the most commonly asked-about PPACA provisions. The ICS recommends that small physician offices take steps to implement those provisions as follows:

- Review the number of full time employees (30 or more hours of work per week) employed in your office to determine whether you are required to pay for or provide health insurance (for employers with fewer than 50 employees, the employer is not required to provide insurance).
- All employers: Post notice of health insurance exchanges. The Department of Labor website provides a form for employers who do not offer employer-sponsored health benefits.
- Small employers who provide health benefits for employees:
  - Post notice of health insurance exchanges. The Department of Labor website provides a form for employers who provide health benefits to their employees.
  - Make sure you provide employees with a Summary of Benefits and Coverage for your employer-sponsored plan. Review office procedures to make sure your SBC is given at hire, at renewal time, and at other changing events.
  - Review your plan’s waiting period to make certain it does not exceed 90 days.
  - If your office offers a Flexible Spending Account, make certain it does not permit employee contributions to exceed $2,500 per year.
  - Consult with your tax professional to see if your office qualifies for a Small Business Health Care Tax Credit to help defray your cost of providing a health insurance benefit.

Regardless of one’s view of the law, these requirements for small employers appear to be manageable at this time. For those seeking more detailed information, the Small Business Administration has additional guidance regarding the impact of the law on small businesses at www.sba.gov.

Save the Dates

2016 Heartland Symposium
March 11th - 12th
Wyndham
Springfield, IL

2016 ICS Chicago National Convention & Expo
October 7th - 9th
Marriott Chicago - Naperville, IL

Save the Date

2016 Capitol Conference
April 6th
Springfield, IL
OPT OUT.. CONTINUED

4. Medicare requires claims submission when a Medicare eligible patient requests that the service be billed; and

First, there is a distinct difference between a covered service and a service that is reimbursable. Below is an excerpt from document “ICN 906143 October 2013” from CMS:

"What are the covered chiropractic services under Medicare? Spinal manipulation is a covered service under Medicare. Acute, chronic, and maintenance adjustments are all “covered” services, but only acute and chronic services are considered active care and therefore, may be reimbursable. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment moves from corrective to supportive in nature, the treatment is then considered maintenance therapy.” [emphasis added]

In the same document, the following can be found:

"Do I have to submit a claim to Medicare, even though I know the service will be denied and the beneficiary has agreed to pay? This is one of the purposes of the Advance Beneficiary Notice (ABN). If you have a covered service you feel will be denied, you would present an ABN to the beneficiary. If they choose Option #1, yes, you would still be required to submit a claim. If the beneficiary chooses Option #2, then you would not be able to submit a claim.” [emphasis added]

Please note that Medicare ABN rules state that providers are prohibited from preselecting options on the ABN for the patient, and that “the patient or authorized representative is to personally select an option.” (Chapter 30 of the Medicare Claims Processing Manual, 70.4.4)

Additionally, in CMS’ Medicare Enrollment and Claim Submission Guidelines, CMS continues to emphasize the requirement to bill for the services rendered. The exceptions listed in this document, are the only exceptions:

"MEDICARE CLAIMS
A claim is defined as a request for payment for benefits or services received by a beneficiary. When you furnish covered services to Medicare beneficiaries, you are required to submit claims for your services and cannot charge beneficiaries for completing or filing Medicare claims. MACs monitor compliance with these requirements. Offenders may be subject to a Civil Monetary Penalty of up to $10,000 for each violation.

Exceptions to Mandatory Claim Filing
You are not required to file claims on behalf of Medicare beneficiaries when:
• The claim is for services for which:
  ◊ Medicare is the secondary payer;
  ◊ The primary insurer’s payment is made directly to the beneficiary; and
• The beneficiary has not furnished the primary payment information needed to submit the Medicare secondary claim;
• The claim is for services furnished outside the United States (U.S.);
• The claim is for services initially paid by a third-party insurer who then files a Medicare claim to recoup what Medicare pays as the primary insurer (for example, indirect payment provisions);
• The claim is for other unusual services, which are evaluated by MACs on a case-by-case basis;
• The claim is for non-covered services, unless the beneficiary requests submission of a claim to Medicare (a supplemental insurer who pays for these services may require a Medicare claim denial notice prior to making payment);
• The beneficiary signed a Beneficiary Notice of Noncoverage, indicating that no claim should be filed for a specific item or service;
• You opted-out of the Medicare Program and entered into a private contract with the beneficiary (when you opt-out of Medicare and privately contract with a beneficiary for the purpose of furnishing items or services that would otherwise be covered, you cannot submit a claim for such services); or [Note: remember, Federal Law precludes chiropractors from opting out of Medicare]
• You have been excluded or debarred from the Medicare Program (when you have been excluded or debarred from the Medicare Program, you cannot submit a claim for your services).” [emphasis added]

These CMS documents, and others, clearly demonstrate that the only way for a chiropractic physician to avoid Medicare requirements is to avoid Medicare eligible patients.