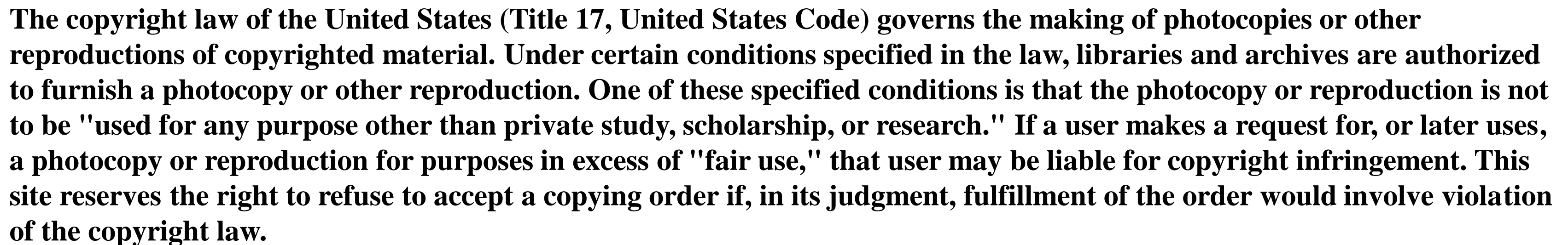
Back To Chiropractic CE Seminars

Ethics & Law Medicare Billing ~ 2 Hours

Welcome to Back To Chiropractic Online CE exams:

This course counts toward your California Board of Chiropractic Examiners CE.
(also accepted in other states, check our website or with your Chiropractic State Board)

The California Board requires that you complete all of your CE hours BEFORE the end of your Birthday month. We recommend that you send your chiropractic license renewal form and fee in early to avoid any issues.



COPYRIGHT WARNING
The copyright law of the United States (Title 17, United States Code) governs the making of photocopies or other reproductions of copyrighted material. Under certain conditions specified in the law, libraries and archives are authorized to furnish a photocopy or other reproduction. One of these specified conditions is that the photocopy or reproduction is not to be "used for any purpose other than private study, scholarship, or research." If a user makes a request for, or later uses, a photocopy or reproduction for purposes in excess of "fair use," that user may be liable for copyright infringement. This site reserves the right to refuse to accept a copying order if, in its judgment, fulfillment of the order would involve violation of the copyright law.

Exam Process: Read all instructions before starting!

1. You must register/pay first. If you haven't, please return to: backtochiropractic.net
2. Open a new window or a new internet tab & drag it so it's side-by-side next to this page.
3. On the new window or new tab you just opened, go to: backtochiropractic.net website.
4. Go directly to the Online section. DON'T register again.
5. Click on the Exam for the course you want to take. No passwords needed.
6. Follow the Exam instructions.
7. Upon passing exam (70%), you'll be able to immediately download your certificate, and it'll also be emailed to you. If you don't pass, you must repeat the exam.

   Please retain the certificate for 5 years. DON'T send it to the state board. If you get audited and lose your records, I'll have a copy.

I'm always a phone call away... 707.972.0047 or email: marcusstrutzdc@gmail.com

Marcus Strutz, DC
Back To Chiropractic CE Seminars
33000 North Highway 1
Ft Bragg CA 95437

MEDICARE BILLING

Ethics & Law – Medicare Billing Requirements – 2 Hours
Back To Chiropractic CE Seminars
Presented by: Steven C Eggleston, DC, Esq.

Objectives

Federal law controls Medicare billing and coding requirements for Chiropractors. The objectives of this course are to instruct California Chiropractors understand the law and to know, understand and use the correct terminology required by federal law. They will be instructed on the legal requirements for Medicare in order to not violate federal law and its very specific legal requirements. Participants will be taught that we are subject to the law and must ethically conform to the law to avoid audits and survive reviews.

MEDICARE BILLING

Hour 1

Participants will be provided legally compliant Medicare SOAP notes forms for Initial Visits, Subsequent Visits and Outcome Assessments for chiropractic patients. Eight common myths about Medicare billing will be dispelled and the legally correct facts will be presented. Participants will be taught common Medicare mistakes that are taken right from the Medicare website which is trying to teach Chiropractors to document properly, ethically and legally under the Medicare system.

MEDICARE BILLING

Hour 2

During hour 2, the eight myths will be presented in detail, citing applicable law such as Medicare Benefit Policy Manual, Chapter 15, Section 240. The Mandatory Claim Submission Rule is explained to help doctors understand their legal and ethical obligations to every senior citizen and other Medicare recipients. The process of audits will be presented and additional resources will be provided including the exact location(s) on the Medicare website where doctors can receive additional information. Doctors will be taught the rules of the "Opt Out" provision of Medicare with legal citations to Section 40.4 of the Medicare Benefits Policy Manual. The rules of ABN are presented as well as the rules for "maintenance" chiropractic coverage. Specifics regarding the legal requirements for paperwork are presented and how durable medical equipment (DME) is paid by Medicare.

MEDICARE BILLING

MYTH #1 – There is a 12 visit cap or limit on chiropractic services under Medicare.

FACT – There are no caps/limits in Medicare for covered chiropractic care rendered by chiropractors who meet Medicare's licensure and other requirements. The Medicare Administrative Contractor (MAC) may have review "screens" but caps are NOT allowed.

MEDICARE BILLING

MYTH #2 – If you are a non-participating (non-par) provider, you do not have to worry about billing Medicare.

FACT – Being non-par does not mean you don't have to bill Medicare. Part B covered services MUST be billed to Medicare by the provider or the provider could face penalties.

MEDICARE BILLING

MYTH #3 – If you are a non-par provider, you will never be audited nor have claims reviewed.

FACT – Any Medicare claim submitted can be audited and/or reviewed. The participation status of the provider does NOT affect the possibility of this occurring.

MEDICARE BILLING

MYTH #4 – You can opt out of Medicare

FACT – Doctors of Chiropractic may NOT opt out of Medicare. Being non-par and opting out are NOT the same thing.

MEDICARE BILLING

MYTH #5 – You should get an Advance Beneficiary Notification (ABN) signed once for each patient and it will apply to all services and all visits.

FACT – The ABN must be based on the expectation that Medicare will NOT pay for a PARTICULAR service because that service will not be considered medically reasonable and necessary in THIS instance.

MEDICARE BILLING

MYTH #6 – Maintenance care is NOT a covered service under Medicare.

FACT – Spinal manipulation IS a covered service under Medicare. However, "maintenance" care is NOT considered by Medicare to be medically necessary. Only acute and CHRONIC spinal manipulation services are considered "active care" and may, therefore, be reimbursable.

MEDICARE BILLING

MYTH #7 – Non-par providers do not have the same documentation requirements as par providers.

FACT – ALL chiropractic care has documentation requirements for anyone over 65 or on Medicare for any other reason (SSDI.) The participating status of the provider is IRRELEVANT to the documentation requirements.

MEDICARE BILLING

MYTH #8 – Durable Medical Equipment (DME) ordered by a DC will be reimbursed by Medicare.

FACT – A chiropractor may act as supplier of DME if s/he has a valid supplier number assigned by the National Supplier Clearing, but a chiropractor will NOT be reimbursed is s/he orders DME for the patient.

COMMON MEDICARE MISTAKES

Missing Signatures
Date of service on billing not found in the records
  (aka) Billing doesn't match records
  (i.e.) Bill for 3-4 levels adjusted but records only
    show symptoms, diagnosis or treatment plan
    for 1 or 2 levels
Required documentation MISSING
Adjusted & billed for an area where no symptoms
Treatment plan absent or insufficient
Calling your treatment "maintenance" in records

COMMON MEDICARE MISTAKES

Claims lack Initial Visit dates for treatment episodes
Not correctly identifying treatment goals in records
Records contain no objective findings
The S, the O, the A or the P don't support the other 3 letters of SOAP

COMMON MEDICARE MISTAKES

Appropriate CPT Codes are:

98940AT 1-2 regions adjusted, active treatment rendered for acute or chronic subluxation
98941AT 3-4 regions adjusted, active treatment rendered for acute or chronic subluxation
98942AT 5 regions adjusted, active treatment rendered for acute or chronic subluxation

USE THESE IF YOU EXPECT TO GET PAID

COMMON MEDICARE MISTAKES

Appropriate CPT Codes are:

98940GA 1-2 regions adjusted, active treatment rendered for acute or chronic subluxation
98941GA 3-4 regions adjusted, active treatment rendered for acute or chronic subluxation
98942GA 5 regions adjusted, active treatment rendered for acute or chronic subluxation

Use these if you DON'T expect to get paid AND you have a correctly done ABN signed by patient

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240 states:

Medicare ONLY covers chiropractic care delivered by MANUAL manipulation to the spine to correct a subluxation. "Manual" includes hand-held devices.

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.1 states:

An X-ray is NOT required to demonstrate the subluxation but MAY be used for this purpose if the chiropractor so chooses.

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.1 states:

The word, "correction" may be used in lieu of "treatment." Other approved terms include "Spine or spinal adjustment by manual means", "spine or spinal manipulation", "manual adjustment" and "vertebral manipulation or adjustment". If you DON'T use these exact words, the claim <u>will be reviewed</u>.

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2 states:

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 remain intact.

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2 states:

An x-ray MAY be used to document subluxation. It MUST have been taken at a time "reasonably proximate" to the initiation of a course of treatment. Generally, it is OK if it was taken "no more than 12 months prior or 3 months following" the initiation of a course of chiropractic treatment.

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2 states:

Any subluxation demonstrated by physical exam MUST demonstrate "asymmetry/misalignment identified on a sectional or segmental level" AND one or more of the following 3: (1) pain/tenderness evaluated in terms of location, quality AND intensity; (2) Range of motion abnormality…

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2 states:

(cont.) or 3) Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia muscle, and ligament.

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2 states:

1) asymmetry/misalignment identified on a sectional or segmental level
2) Pain/tenderness (location, quality, intensity)
3) ROM abnormality
4) Tissue, tone changes in contiguous soft tissues

NOTE: #1 REQUIRED + any ONE more

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2 states:

The HISTORY of a Medicare patient's records MUST contain the following:
Symptoms causing patient to seek treatment
Family history if relevant, Past health history (e.g. injuries, surgical hx), Mechanism of trauma, Quality of symptoms, Onset (duration, intensity, frequency, location, ratiation)
Aggravating/relieving factors, & prior treatments

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2 states:

The symptoms must bear a DIRECT relationship to the level of subluxation. The words to use include "algia" and "itis" the specific struction that is painful or inflammed. Spondylalgia or spondylitis, myalgia or myositis, arthralgia or arthritis, costalgia or costitis, osteoalgia or osteoitis.

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2 states:

The PRIMARY diagnosis MUST be "subluxation" including the level of the subluxation, either so stated or identified by a term descriptive of the subluxation.

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2 states:

The TREATMENT plan SHOULD include the following:

1) Recommended duration and frequency of tx
2) Specific treatment goals; and
3) Objective measures to evaluate treatment effectiveness.

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2 states:

Documentation for SUBSEQUENT visits:

1) Hx (review of complaint, changes since last visit and system review if relevant)
2) Physical exam (exam of spine area named in the diagnosis, assessment of change & evaluation of treatment effectiveness)
3) Exact treatment given that day

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3 states:

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 function.

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3 states:

Acute Subluxation – New injury demonstrated by x-ray or physical exam. Goal of treatment MUST be to make an "improvement in, or arrest of progression of the patient's condition."

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3 states:

Chronic subluxation – When no significant improvement is expected and further treatment is not expected to resolve the condition BUT where the treatment can be expected to result in some FUNCTIONAL improvement.
NOTE: Once the condition is "stable" then additional treatments are "maintenance" and not covered by Medicare.

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3 states:

Maintenance Therapy – treatment to prevent disease, promote health and prolong or enhance the quality of life, or maintain or prevent deterioration of a chronic condition. The AT modifier must not be placed on a claim when maintenance therapy has been provided. Claims without the AT modifier will be denied. If you have an ABN, use a GA modifier on the claim.

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.4 states:

The PRECISE level of subluxation MUST be written in your chart. (e.g C0, C1, C5, T4, R1, R3, L3, L5, SI, S, or SC)

The BEST way is to name the motion segment such as C4-5 or T11-12.

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.4 states:

Acceptable descriptive terms for the nature of the abnormalities include:
Off-centered, Misalignment, Malpositioning
Spacing abnormal/altered/decreased/increased, Incomplete dislocation, Rotation, Listhesis (e.g. antero, postero, retro, lateral, spondylo) and Motion (e.g. limited, lost, flexion, extension, hyper or hypomobility, aberrant.)

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.5 states:

Treatment parameters: The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxations may require as many as 3 months. Chronic may require longer time but NOT increased frequency

MYTH #1 – 12 VISIT CAP

The Medicare Benefit Policy Manual, Chapter 15, Section 240.1.5 states:

Treatment parameters: So-called "intensive" care with multiple treatments per day will only be paid by Medicare for ONE treatment per day.

MYTH #1 – 12 VISIT CAP

Is there a 12 Visit Cap? Absolutely not.

Medicare is a "legal" system governed by rules and regulations, not a medical system.

Since the law is incredibly malleable, simply provide Medicare what they want to satisfy these legal requirements and you should have no problem being paid for any "reasonable" number of Medicare visits. FOLLOW THE RULES AND BE HONEST !!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

MYTH #2 – NON-PAR DON'T BILL

The "Mandatory Claim Submission Rule" applies to EVERY single Medicare patient whether you are par or non-par.

a non-par chiropractor must still submit a bill to Medicare even if the patient pays him/her directly. This is so the patient may be reimbursed by Medicare.

Non-par providers may accept assignment and report in item 29 of the CMS 1500 what the patient paid.

MYTH #2 – NON-PAR DON'T BILL

The Medicare Participating Provider Agreement is found at:
http://www.cms.gov/Medicare/CMS-forms/CMS-Forms-List.html

You can find Section 240 of the Medicare Benefit Policy Manual on my website at
www.hbtinstitute.com
Go to Doctor Forms
User Name – great   Password - doctor

MYTH #3 – NON-PAR = NO AUDITS

CMS audits/reviews are intended to protect Medicare trust funds and also to identify billing errors so providers and their billing staff can be alerted of errors and educated on how to avoid future errors.

See http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html

MYTH #4 – YOU CAN OPT OUT

DCs may NOT "opt out" of Medicare. Opting out and being non-par are not the same thing.

Opt-out refers to physicians' ability to decide not to bill Medicare at all and then entering into private contracts with Medicare beneficiaries they treat. Services furnished under these private contracts that meet the opt out requirements are not covered services under Medicare and no payment is made for those services by Medicare.

MYTH #4 – YOU CAN OPT OUT

ONLY M.D.s, D.O.s and Dentists may "opt out" of Medicare. The Medicare Benefits Policy Manual Section 40.4 specifically states that chiropractor are not defined as physicians for the purpose section 40, the "opt out" section.

MYTH #5 – ONE ABN IS ALL YOU NEED

The ABN has 3 boxes:
Option 1) Patient agrees to pay out of pocket and requests that the chiropractor file a claim for that service with Medicare. DC may ask for payment from patient BEFORE claim is filed if #1 chosen.

Option 2) Patient agrees to pay out of pocket and does NOT want a claim sent to Medicare. DC does NOT file a claim and patient has NO appeal rights. Patient can change mind later and request claim filed

MYTH #5 – ONE ABN IS ALL YOU NEED

The ABN has 3 boxes:
Option 3) Patient selects this box on the ABN when s/he chooses NOT to receive and pay for service. No service is rendered and no claim is filed. Since no claim is filed, the patient cannot appeal to Medicare for a payment decision.

MYTH #5 – ONE ABN IS ALL YOU NEED

An ABN is issued EACH TIME a patient receives a Medicare covered service that the DC believes will not be covered.

Providers may issue a single ABN to a patient receive the same service multiple times on a continuing basis (i.e. lumbar spinal manipulation monthly for a year.)

ABNs for repetitive services can be effective for UP TO one year. New ABN if "different" services done.

MYTH #6 – MAINTENANCE NOT COVERED

This is a semantics problem…

Medicare defines "maintenance" as not medically necessary so… get over it

Only "active care" is covered (acute and chronic spinal manipulation services)

MYTH #7 – NON-PAR=LESS PAPERWORK

All chiropractic care rendered to anyone over 65 or on SSDI has documentation requirements.

The participating status of the doctor is irrelevant to the documentation requirements.

MYTH #8 – DME IS PAID BY CMS

DCs may act as a supplier of durable medical equipment (DME) is s/he has a valid supplier number assigned by the National Supplier Clearinghouse, but a chiropractor will NOT be reimbursed if s/he orders DME.

The application process is long and daunting but if you use ONLY reputable supply companies, reimbursement for braces, TENs units and traction devices is available to you.

WOULDN'T A FORM BE NICE?

www.hbtinstitute.com
go to Doctor Forms
User name – great
Password – doctor
ICD-10 compliant, Medicare compliant forms

designed by yours truly…

MEDICARE BILLING

Questions?

Steven C Eggleston, DC, Esq.
2601 Main St., Suite 800
Irvine, California 92614
(877) 424-4765

Thanks for taking Online Courses with Back To Chiropractic CE Seminars.
I hope you enjoyed the course. Please feel free to provide feedback.

Check out: Back To Chiropractic Resource Pages
Chiropracticpedia Informational website for chiropractic patients
Free Materials Over 200 files: Posters, newsletters & more
Adjusting & Office Skills Free help from DCs that care
DCs Looking For DCs Looking to hire, or for a job?
Chiropractic Neurologists
Classifieds Looking to buy or sell a Practice
Memorials Tributes to great DCs who have passed

Marcus Strutz DC
Back To Chiropractic CE Seminars
33000 North Highway 1
Ft Bragg CA 95437
707.972.0047