Medicare Common Questions Answered

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

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.