WHAT CA'S NEED TO KNOW ABOUT MEDICARE

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1

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2

What's Medicare?

Medicare is health insurance for:

- People 65 or older
- Under 65 with certain disabilities
- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)

3

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) **PROVIDES HEALTH COVERAGE TO MORE THAN 100 MILLION PEOPLE** THROUGH MEDICARE, MEDICAID, THE CHILDREN'S HEALTH INSURANCE PROGRAM, AND THE HEALTH INSURANCE MARKETPLACE.

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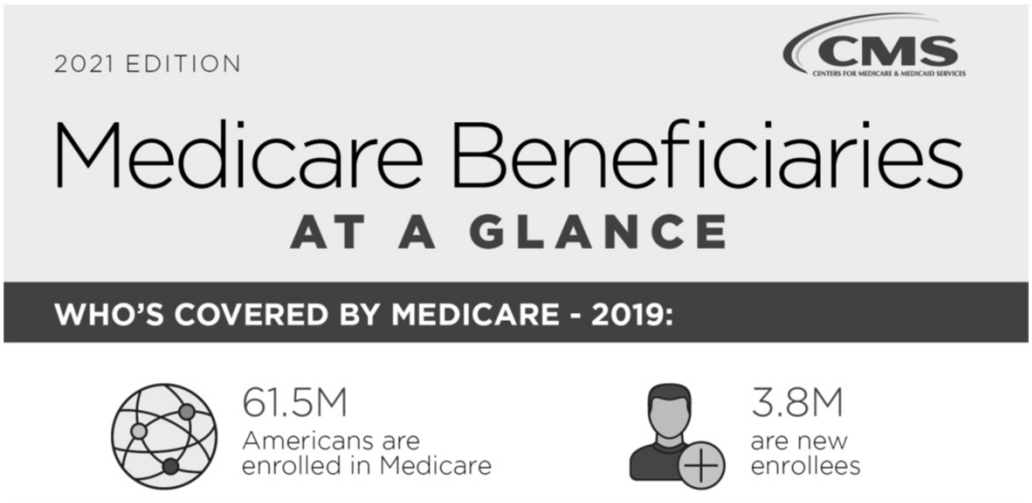

Represents 18.66% of the US Population as of the 2020 Census (329.5 Million)

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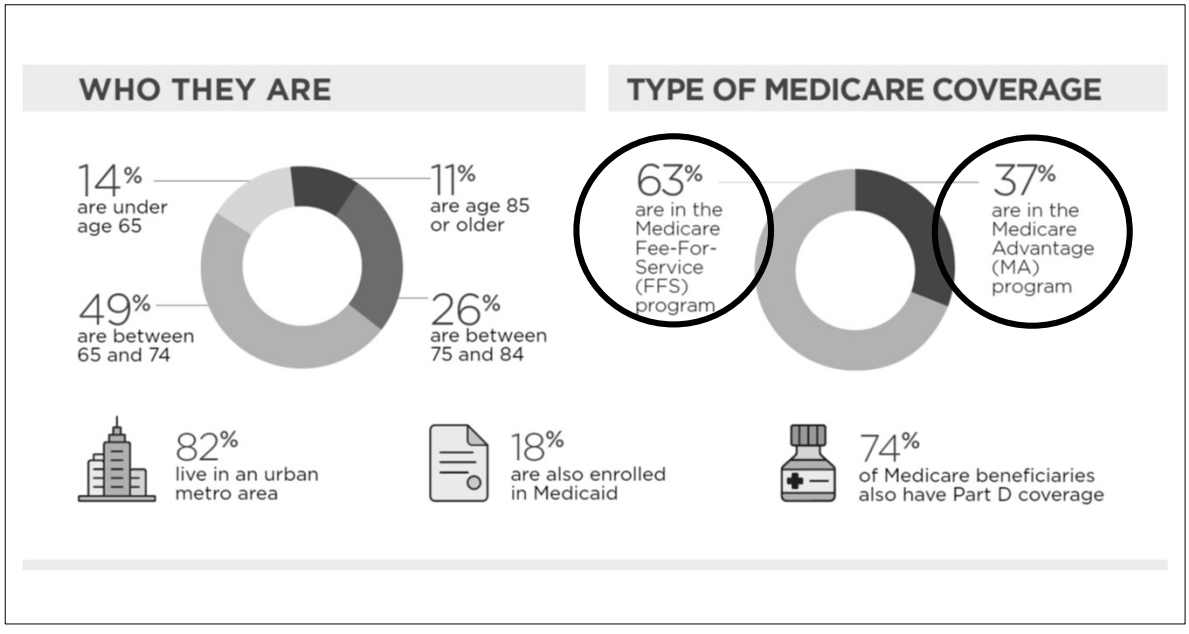

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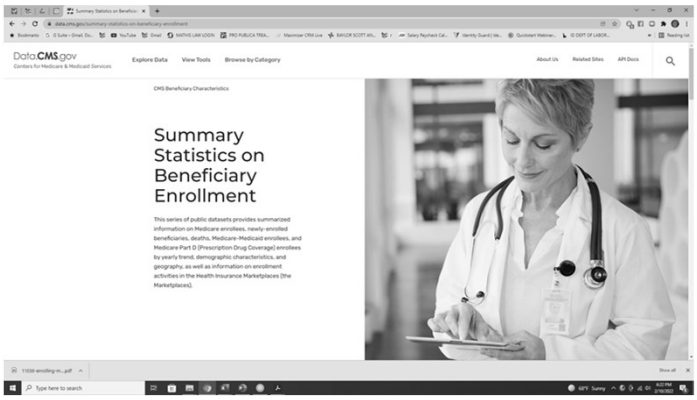
HOW MANY MEDICARE PATIENTS ARE IN MY STATE?



https://data.cms.gov/summary-statistics-on-beneficiary-enrollment

7

MDCR ENROLL AB 2

Total Medicare Enrollment: Total, Original Medicare, and Medicare Advantage and Other Health Plan Enrollment and Resident Population, by Area of Residence, Calendar Year 2020

Area of Residence	State Population[1]	Total Medicare Enrollment	Total Medicare Enrollment Percent of Resident Population	Original Medicare Enrollment	Original Medicare Enrollment Percent of Total Enrollment	Medicare Advantage and Other Health Plan Enrollment	Medicare Advantage and Other Health Plan Enrollment Percent of Total Enrollment	Total Enrollment Metropolitan Residence	Total Enrollment Micropolitan Residence	Total Enrollment Non-Core-Based Statistical Area
United States[2]	329,484,123	61,551,947	18.7	37,094,414	60.3	24,457,533	39.7	50,831,208	6,190,674	4,530,066
Vermont	623,347	[illegible]	24.3	[illegible]	85.6	[illegible]	14.4	42,936	64,546	43,821
Virginia	8,590,563	1,545,578	18.0	1,157,274	74.9	388,305	25.1	1,256,500	72,211	216,868
Washington	7,693,612	[illegible]	18.2	[illegible]	63.5	[illegible]	36.5	1,192,938	146,556	59,443
West Virginia	1,784,787	442,688	24.8	275,122	62.2	167,566	37.9	273,660	74,085	94,942
Wisconsin	5,832,655	1,200,527	20.6	645,403	53.8	555,124	46.2	831,777	169,635	199,116
Wyoming	582,328	113,802	19.5	108,216	95.1	5,587	4.9	34,414	45,196	34,193

8

MDCR ENROLL AB 1

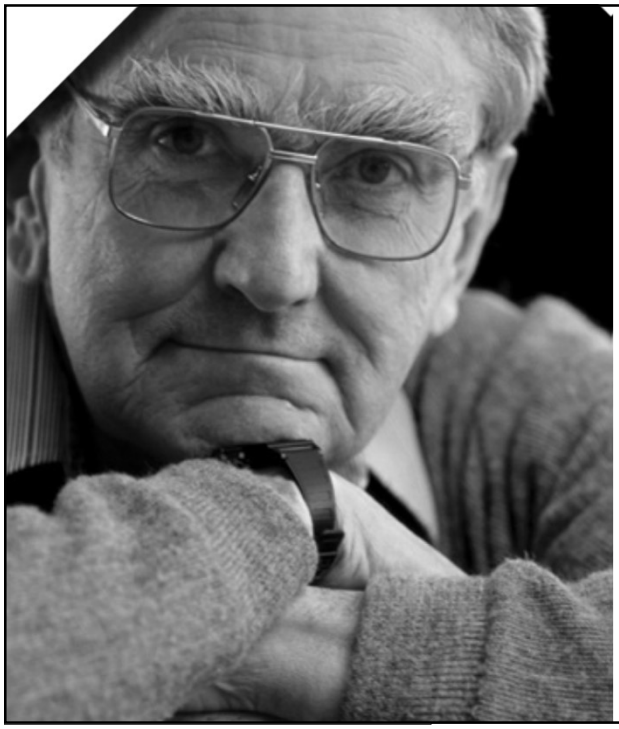
Total Medicare Enrollment: Total, Original Medicare, and Medicare Advantage and Other Health Plan Enrollment, Calendar Years 2015-2020

Year	Total Enrollment	Total Enrollment Percentage Increase from Prior Year	Total Original Medicare Enrollment	Total Original Medicare Enrollment Percentage Increase from Prior Year	Total Original Medicare Percent of Total Enrollment	Total Medicare Advantage and Other Health Plan Enrollment	Total Medicare Advantage and Other Health Plan Enrollment Percentage Increase from Prior Year	Total Medicare Advantage and Other Health Plan Enrollment Percent of Total Enrollment
2015	55,496,222	2.75	38,025,274	0.62	68.52	17,470,948	7.69	31.48
2016	56,981,183	2.68	38,610,384	1.54	67.76	18,370,800	5.15	32.24
2017	58,457,244	2.59	38,667,830	0.15	66.15	19,789,414	7.72	33.85
2018	59,989,883	2.62	38,665,082	-0.01	64.45	21,324,800	7.76	35.55
2019	61,514,510	2.54	38,577,012	-0.23	62.71	22,937,498	7.56	37.29
2020	62,840,267	2.16	37,776,345	-2.08	60.11	25,063,922	9.27	39.89

NOTES: The enrollment counts are determined using a person-year methodology. Numbers and percentages may not add to totals because of rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Enterprise Data and Analytics, CMS Chronic Conditions Data Warehouse.

9



THE 'PARTS' OF MEDICARE

10

WHAT ARE THE PARTS OF MEDICARE?

Part A (Hospital Insurance)

Helps cover:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care

❑Part A is automatic upon reaching eligibility for Medicare

❑Paid for by 40 quarters of employee contributions, no monthly premium

❑If contribution requirement not met, Part A is available by paying a monthly premium

11

WHAT ARE THE PARTS OF MEDICARE?

Part B (Medical Insurance)

Helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits)

❑ Part B is automatic upon reaching eligibility for Medicare

❑ Requires additional monthly premium.

❑ Requires patient to opt out or REPLACE coverage

12

WHAT ARE THE PARTS OF MEDICARE?

Part D (Drug coverage)

Helps cover the cost of prescription drugs (including many recommended shots or vaccines).

Plans that offer Medicare drug coverage (Part D) are run by private insurance companies that follow rules set by Medicare.

13

Medicare Part C (also known as Medicare Advantage)

Medicare Advantage Plans (like HMOs or PPOs) provide your Part A and Part B coverage and many times offer additional benefits. Private insurance companies approved by Medicare run these plans. Generally, you must see doctors in the plan. Most Medicare Advantage Plans cover prescription drugs (Medicare Part D). You choose the Medicare Advantage Plan (with or without prescription drug coverage) and pay a monthly premium. Costs vary by plan.

WHAT ARE THE PARTS OF MEDICARE?

14

COMPARISON OF ORIGINAL MEDICARE AND MEDICARE ADVANTAGE

ORIGINAL MEDICARE

- ☑ Part A
- ☑ Part B

You can add:

- ☐ Part D

You can also add:

- ☐ **Supplemental coverage**
  This includes Medicare Supplement Insurance (Medigap). See Section 5 (starting on page 75) to learn more about Medigap. Or, you can use coverage from a former employer or union, or Medicaid.

MEDICARE ADVANTAGE

- ☑ Part A
- ☑ Part B

Most plans include:

- ☑ Part D
- ☑ Some extra benefits

15

Original Medicare vs. Medicare Advantage

Doctor and hospital choice

Original Medicare	Medicare Advantage
You can go to **any doctor that accepts Medicare**.	In most cases, you'll need to use **doctors who are in the plan's network** (for non-emergency or non-urgent care). Ask your doctor if they participate in any Medicare Advantage Plans.
In most cases you **don't need** a referral to see a specialist.	You **may need** to get a referral to see a specialist.

DIFFERENCE BETWEEN MEDICARE A/B AND MEDICARE ADVANTAGE

CHOICE OF HOSPITALS AND/OR HEALTH CARE PROVIDERS

16

ONE KEY ELEMENT TO SUCCESSFUL PROCESSING OF MEDICARE CLAIMS IS UNDERSTANDING HOW TO CORRECTLY PROFILE A MEDICARE PATIENT IN YOUR BILLING SOFTWARE

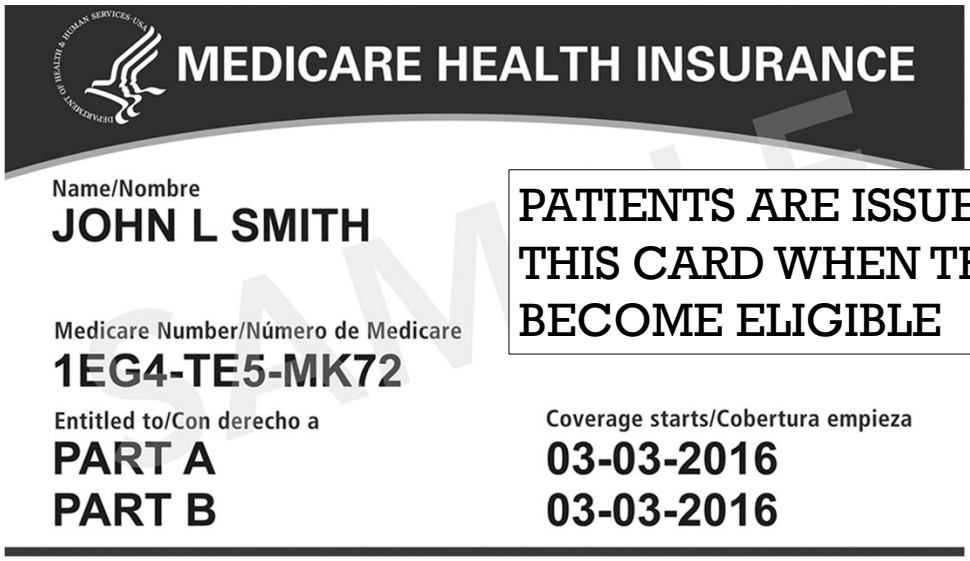
IF A PATIENT BRINGS YOU A BUNCH OF INSURANCE CARDS, HOW DO YOU KNOW WHICH IS PRIMARY OR SECONDARY?

IF YOU GET THIS WRONG IT COULD TAKE WEEKS OR MONTHS TO GET PAID!

17

COORDINATING BENEFITS

18



PATIENTS ARE ISSUED THIS CARD WHEN THEY BECOME ELIGIBLE

19

This is a Medicare Supplemental Plan, aka Medigap

It is Supplemental to Medicare Part B

Plan "Letter" Determines Level of Payment

20

PLAN F

Benefits	Medigap plans									
	A	B	C	D	F*	G*	K	L	M	N
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-pocket limit in 2020**			
							$5,880	$2,940		

Supplemental Plans are designed to "gap" Medicare Coverage. If Medicare pays 80%, the supplemental plan takes care of the 20% at the rate indicated by the medigap plan.

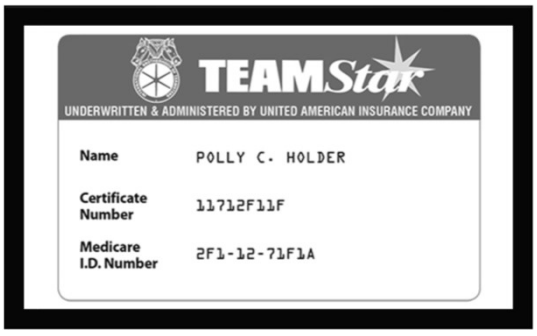
Most Medigap plans do NOT pay for services that Medicare does not cover.

Most Supplemental plans are "crossover" plans, and billing is not necessary. Medicare B forwards the claim info to the Medigap plan directly

21

"TRUE" SECONDARY PLAN

- Some retirement and union plans provide true secondary policies.
- These plans may provide expanded coverage such as payment for exams, x-rays and therapies
- If the insurance card is not clearly a Medigap plan, **verify benefits**
- These types of plans may also not crossover directly from Medicare. Manual secondary billing may be necessary



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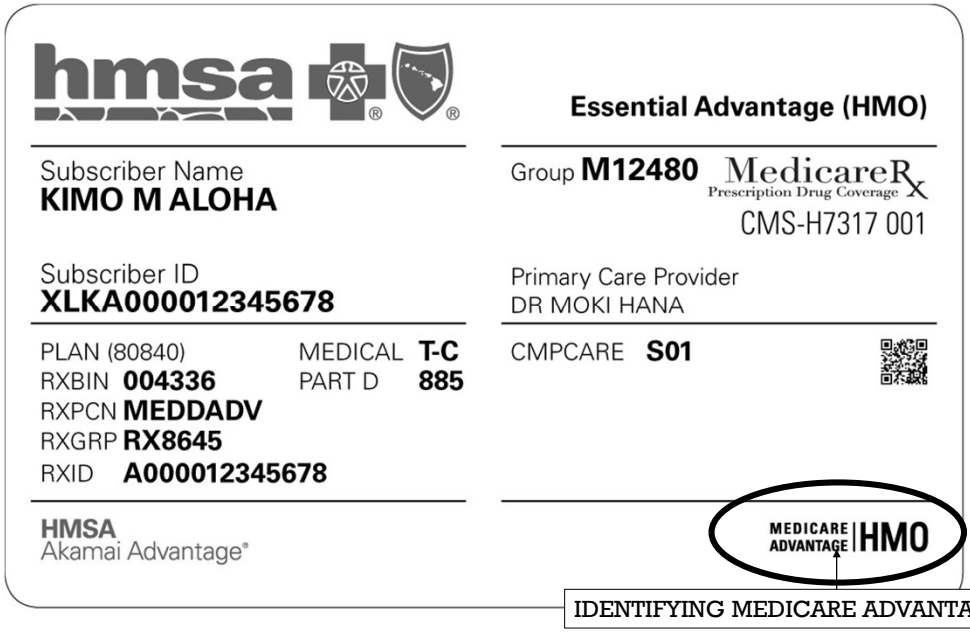

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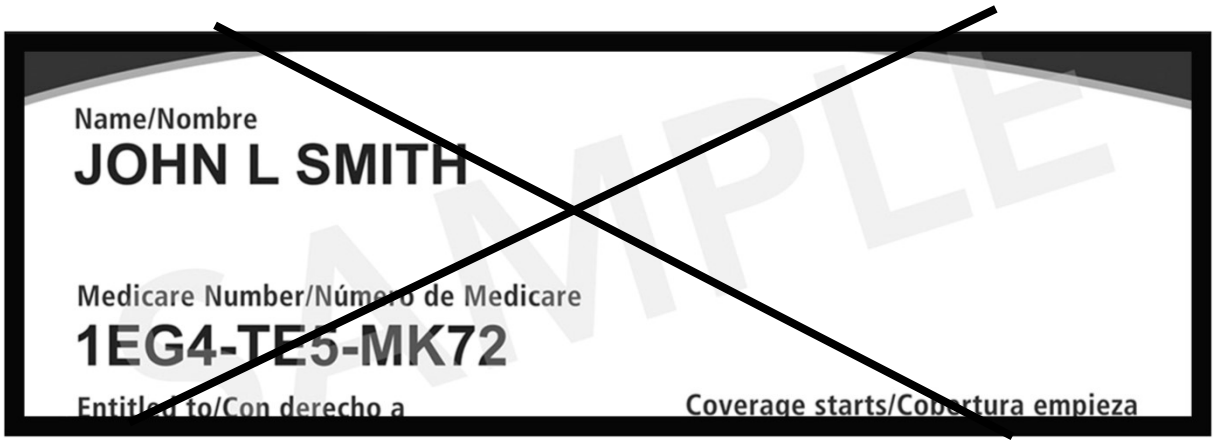
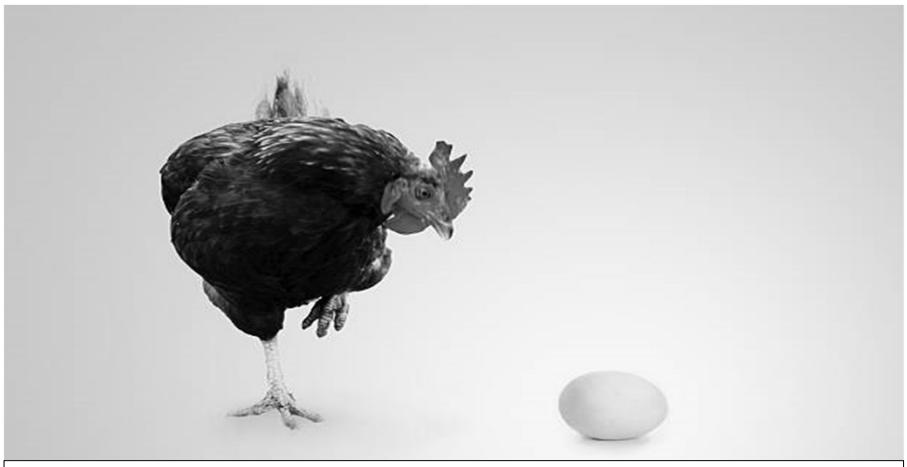


IF A PATIENT HAS A MEDICARE ADVANTAGE PLAN, DO NOT ENTER THIS CARD IN THE BILLING SYSTEM- JUST KEEP A COPY ON FILE

24

MEDICARE AS A SECONDARY PAYER



25

How does my other insurance work with Medicare?

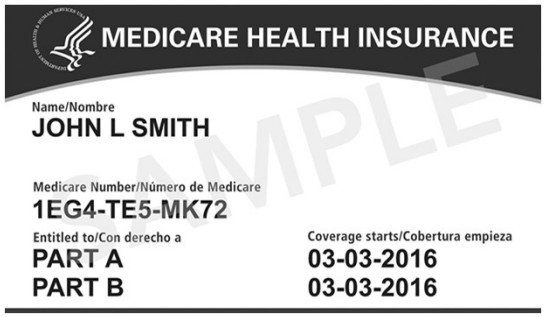
When you have other insurance and Medicare, there are rules for whether Medicare or your other insurance pays first.

If you have **retiree** insurance (insurance from your or your spouse's former employment)...	Medicare pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's **current** employment, and the employer has **20 or more employees**...	Your group health plan pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's **current** employment, and the employer has **fewer than 20 employees**...	Medicare pays first.
If you're under 65 and have a disability, have group health plan coverage based on your family member's **current** employment, and the employer has **100 or more employees**...	Your group health plan pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family member's **current** employment, and the employer has **fewer than 100 employees**...	Medicare pays first.
If you have Medicare because of End-Stage Renal Disease (ESRD)...	Your group health plan will pay first for the first 30 months after you become eligible to enroll in Medicare. Medicare will pay first after this 30-month period.

Instances where Medicare may be secondary

26

WHEN A PATIENT BRINGS YOU THIS…



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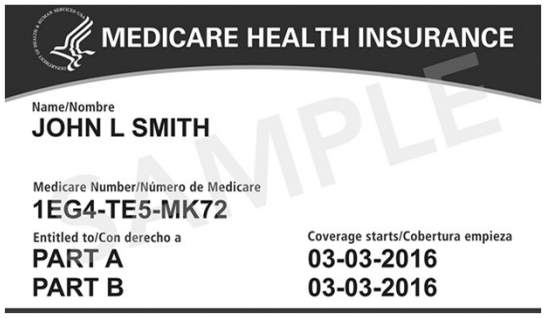
27

WHEN A PATIENT BRINGS YOU THIS…

Check Benefits, may be a true secondary



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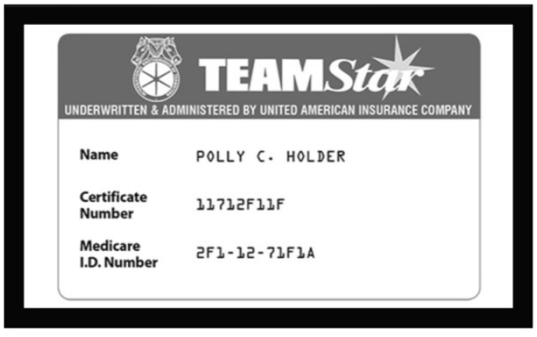

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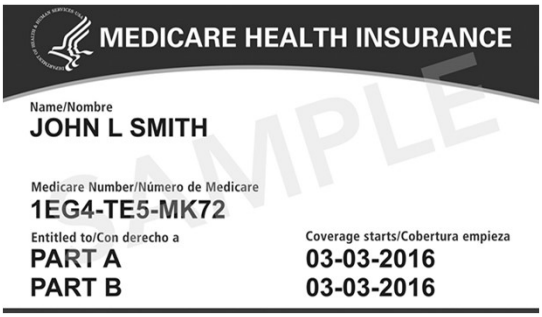
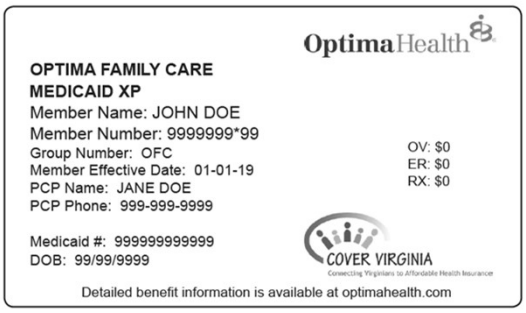
28

WHEN A PATIENT BRINGS YOU THIS…

Dual Eligible Patient





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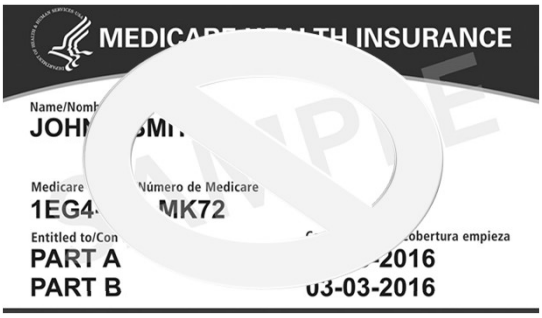
29

WHEN A PATIENT BRINGS YOU THIS…

Medicare Advantage REPLACES Medicare B



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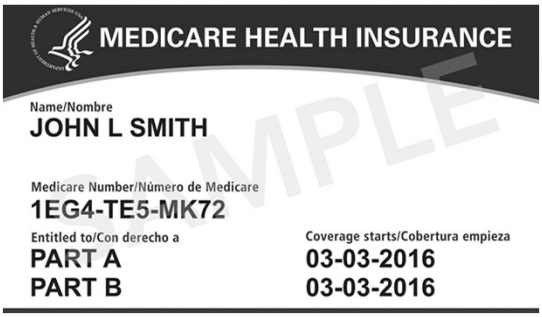
30

WHEN A PATIENT BRINGS YOU THIS…
STILL WORKING, 60 EMPLOYEES



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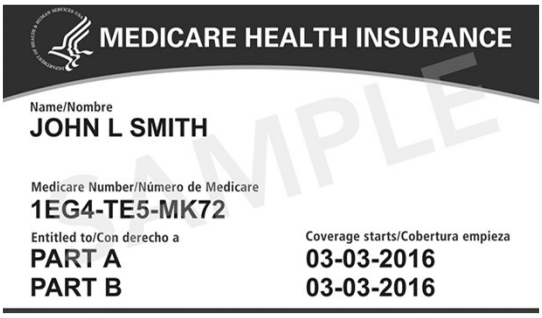
31

WHEN A PATIENT BRINGS YOU THIS…
AUTO ACCIDENT



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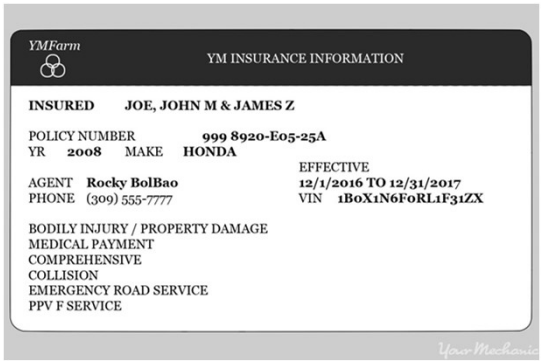

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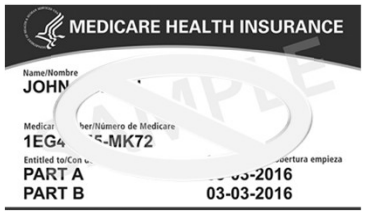
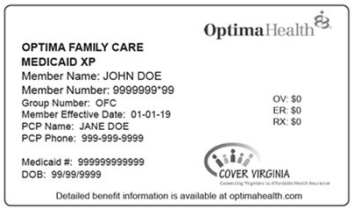
32

WHEN A PATIENT BRINGS YOU THIS…

Dual Eligible MA Patient





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33

HOW PROVIDER ENROLLMENT AFFECTS MEDICARE CLAIMS

- **Medicare Part B** – is your provider PAR or NON-PAR?
  - Par – Bill Medicare for Covered services, collect cost share (if any) and $$ for non covered services
  - Non-Par – Bill Medicare for Covered Services, collect full fee (up to limiting charge, more on this later) and $$ for non-covered services. Non par providers usually do not accept assignment. Make sure assignment box is marked "no". (CMS 1500 form box 27)
- **Medicare Advantage** – Payment will be based on whether the provider is in or out of network with the Payer offering the Advantage plan.

34

COMPARE PAR VS. NON PAR PROVIDERS

Participating Provider or Supplier

- Medicare pays 5% more to participating physicians and other suppliers
- Because these are assigned claims, Medicare pays you directly
- Medicare forwards claim information to Medigap (Medicare supplement coverage) insurers

Non-Participating Provider or Supplier

- Medicare pays 5% less to non-participating physicians and other suppliers
- You can't charge the patient more than the limiting charge, 115% of the Medicare Physician Fee Schedule amount
- You may accept assignment on a case-by-case basis
- You have limited appeal rights

You must bill Medicare for covered services regardless of whether you are par or non-par

35

DEEMED PROVIDER UNDER MA PLANS

- When an enrollee in a private fee for service (PFFS) plan offered by a Medicare Advantage (MA) Organization obtains services from a provider, then for those services, that provider is classified into one of the following three mutually exclusive provider types:
- A provider is a **direct-contracting** provider if that provider has a direct contract (that is, a signed contract) with the MA Organization *(meaning they are already contracted as an "in network" provider in that plan)*
- A provider is a **deemed-contracting** provider if:
- The provider is aware in advance of furnishing services, that the person receiving the services is enrolled in a PFFS plan
- The provider has **reasonable access** to the plan's terms and conditions of payment; and the service provided is covered by the plan
- *A* provider is **non-contracting provider** if that provider does not have a direct *contract* and is not **deemed**

36

DEEMED PROVIDER UNDER MA PLANS

- A provider is "aware in advance" of enrollment if notice of enrollment for this enrollee was obtained from:
- The enrollee (e.g., presentation of an enrollment card)
- CMS
- A Medicare intermediary
- A carrier
- The MA Organization itself
- A provider has "reasonable access" to the plan's terms and conditions of payment if the plan makes accessible its terms and conditions of payment through:
- Mail
- E-mail
- Fax
- Telephone
- A plan Web site

37

EXAMPLE OF DEEMING

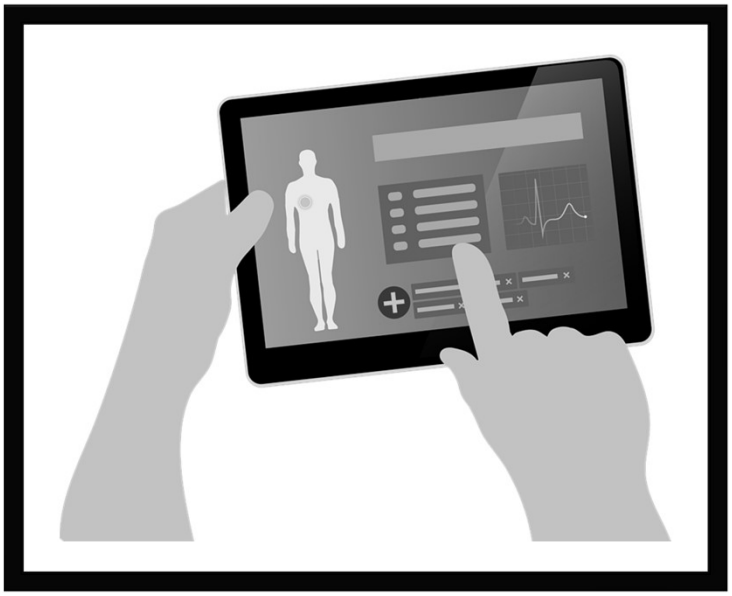
- The following examples illustrate typical situations in which the provider becomes deemed contracting:
- An enrollee walks into a physician's office for the first time, advises the physician that he or she is a member of the PFFS plan and presents his or her plan enrollment card.
- **Since the provider had the opportunity to call the plan phone number on the enrollee card, the provider is considered deemed contracting as soon as s/he provides services, even though the provider did not actually check the terms and conditions of payments.**
- **Once the provider is "DEEMED" they must accept terms of payment and reimbursement. So if there are no benefits, and the provider did not notify the patient in advance that they were out of network with their plan, the provider could not balance bill the patient for the non covered services.**

38

I DON'T TAKE MEDICARE

- Chiropractors cannot opt out of Medicare.
- Chiropractors must enroll as either a PARTICIPATING or NON PARTICIPATING provider
- Chiropractors who are not enrolled in Medicare may not accept Medicare patients
- Chiropractors who are not enrolled in Medicare must refer patients out who "age in" to Medicare

39



CHIROPRACTIC COVERAGE

WHAT DOES MEDICARE PAY FOR?

40

MEDICARE COVERAGE OF CHIROPRACTIC (NATIONAL POLICY)

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

Table of Contents
(Rev. 10639, 03-12-21)
(Rev. 10573, 03-24-21)

41

MEDICARE COVERAGE OF CHIROPRACTIC

30.5 - Chiropractor's Services

(Rev. 23, Issued: 10-08-04, Effective: 10-01-04, Implementation: 10-04-04)
B3-2020.26

A chiropractor must be licensed or legally authorized to furnish chiropractic services by the State or jurisdiction in which the services are furnished. In addition, a licensed chiropractor must meet the following uniform minimum standards to be considered a physician for Medicare coverage. Coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation provided such treatment is legal in the State where performed. All other services furnished or ordered by chiropractors are not covered.

42

MAINTENANCE THERAPY

B. Maintenance Therapy

Under the Medicare program, Chiropractic maintenance therapy is not considered to be medically reasonable or necessary, and is therefore not payable. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. For information on how to indicate on a claim a treatment is or is not maintenance, see §240.1.3.

43

CONDITIONS THAT WARRANT ACTIVE TREATMENT

- Acute subluxation-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.

44

CONDITIONS THAT WARRANT ACTIVE TREATMENT

- Chronic subluxation-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.

45

46

CPT CODES THAT ARE COVERED

- 98940- CMT 1-2 Regions
- 98941- CMT 3-4 Regions
- 98942- CMT 5 Regions

47

MEDICARE ALLOWABLES (PARTICIPATING PROVIDER)

•98940- CMT 1-2 Regions	$27.94
•98941- CMT 3-4 Regions	$40.03
•98942- CMT 5 Regions	$52.44

2022 Medicare Fee Schedule- Locality Virginia https://www.cms.gov/medicare/physician-fee-schedule/

48

MEDICARE ALLOWABLES (NON-PARTICIPATING PROVIDER LIMITING CHARGE)

- 98940- CMT 1-2 Regions $30.53
- 98941- CMT 3-4 Regions $43.73
- 98942- CMT 5 Regions $57.29

2022 Medicare Fee Schedule- Locality Virginia https://www.cms.gov/medicare/physician-fee-schedule/

49

ABOUT THE NON-PAR LIMITING CHARGE

- **Limiting Charge:** Only applies when the provider chooses not to accept assignment. (Patient pays up front)
- **The Limiting Charge** is the maximum amount a nonparticipating provider may legally charge a beneficiary when filing an unassigned claim.

https://medicarepaymentandreimbursement.com/

50

PRIMARY DX CODES-SUBLUXATION (SEGMENTAL AND SOMATIC DYSFUNCTION)

- M99.01- OF CERVICAL REGION
- M99.02- OF THORACIC REGION
- M99.03- OF LUMBAR REGION
- M99.04- OF SACRAL REGION
- M99.05- OF PELVIC REGION

THESE ARE THE <u>ONLY</u> CODES PERMITTED IN BOX 21A OF THE CMS 1500 CLAIM FORM (Palmetto GBA)

MEDICARE CODES: THESE CODES ARE NOT NORMALLY USED IN COMMERCIAL PAYER SCENARIOS

51

-**AT:** Appended to CMT code to indicate patient is undergoing **ACUTE TREATMENT** to correct a Subluxation

-**GA**: Appended to CMT code to indicate that the patient is no longer under Active Treatment and they have signed an **Advance Beneficiary Notice, choosing OPTION 1** (more on this later)

-**GY:** Appended to all **Statutorily NON COVERED services** that may be be billed to Medicare

-**GP:** Appended to Physical Therapy codes 97xxx to indicate the patient is under a **Physical Therapy Plan of Care**

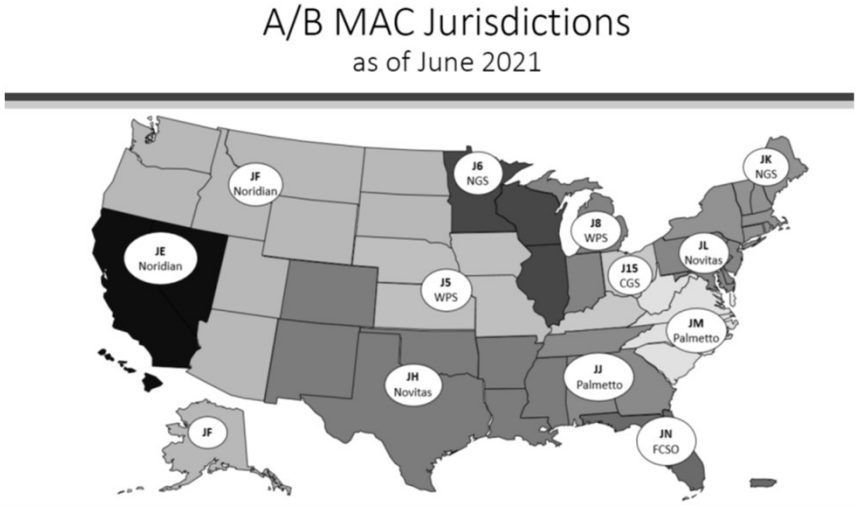
COMMON MODIFIERS USED IN CHIROPRACTIC BILLING OF MEDICARE B

52

For Medicare purposes, a chiropractor **must** place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary. As always, contractors may deny if appropriate after medical review.

THE –AT MODIFIER

53



WHO IS MY MEDICARE PART B ADMINISTRATIVE CONTRACTOR (MAC)?

- Palmetto GBA, Jurisdiction M (Most of Virginia)
- Novitas Solutions, Jurisdiction L (Part B for counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia)

54

LCD'S AND LCA'S

- **LCD= LOCAL COVERAGE DETERMINATION**
  - Provides information on how to establish medical necessity, limitations and documentation requirements for initial and subsequent visits (Palmetto LCD is document L37387)
- **LCA= LOCAL COVERAGE ARTICLE**
  - Provides Billing and Coding Guidance (Palmetto LCA is Document A56616)

55

- **LCD/LCA RULES**
  - Always use the LCD/LCA for your MAC (Medicare Administrative Contractor)
  - Always use the most recent version

LCD'S AND LCA'S

56

FROM THE PALMETTO LCA

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes:

CODE	DESCRIPTION
98940	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 1-2 REGIONS
98941	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 3-4 REGIONS
98942	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 5 REGIONS

57

FROM THE PALMETTO LCA

CPT/HCPCS Modifiers

Group 1 Paragraph:

N/A

Group 1 Codes:

CODE	DESCRIPTION
AT	ACUTE TREATMENT (THIS MODIFIER SHOULD BE USED WHEN REPORTING SERVICE 98940, 98941, 98942)

58

ICD-10-CM Codes that Support Medical Necessity

Group 1 Paragraph:

The use of an ICD-10-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in the Chiropractic Services L37387 LCD.

Group 1 Codes:

CODE	DESCRIPTION
M99.01	Segmental and somatic dysfunction of cervical region

CODE	DESCRIPTION
M99.02	Segmental and somatic dysfunction of thoracic region
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.05	Segmental and somatic dysfunction of pelvic region

PALMETTO LCA

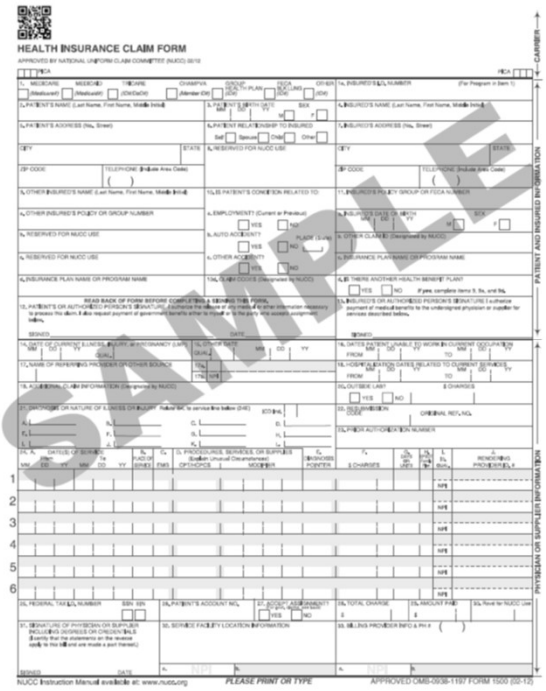
59

NOVITAS LCA

Group 1 Codes: (12 Codes)

CODE	DESCRIPTION
M99.00	Segmental and somatic dysfunction of head region
M99.01	Segmental and somatic dysfunction of cervical region
M99.02	Segmental and somatic dysfunction of thoracic region
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.05	Segmental and somatic dysfunction of pelvic region
M99.10	Subluxation complex (vertebral) of head region
M99.11	Subluxation complex (vertebral) of cervical region
M99.12	Subluxation complex (vertebral) of thoracic region
M99.13	Subluxation complex (vertebral) of lumbar region
M99.14	Subluxation complex (vertebral) of sacral region
M99.15	Subluxation complex (vertebral) of pelvic region

60



CMS 1500 CLAIM FORM (VER. 2/12)

MOST CLAIMS FILED ELECTRONICALLY

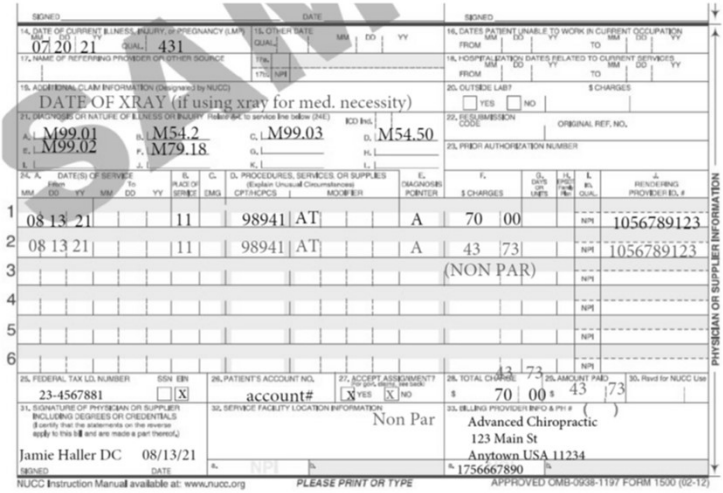
"THE BOXES" OF A CMS 1500 CLAIM FORM ARE KNOWN AS LOOPS AND SEGMENTS IN 5010 ELECTRONIC CLAIMS TRANSACTIONS

MOST BILLERS AND INSURANCE COMPANIES STILL REFER TO THE 33 "BOXES" OF A CMS 1500 CLAIM FORM WHEN DISCUSSING CLAIMS

THREE MAIN SECTIONS:

- 1-13 ABOUT THE PATIENT
- 14-24 ABOUT THE PROCEDURE
- 25-33 ABOUNT THE FINANCIALS

61



Example of a Medicare Claim for Chiropractic: Patient under ACTIVE TREATMENT

Items in BLUE would be the set up for a NON PAR, NON ASSIGNED CLAIM

62

BILLING NON-COVERED SERVICES

INCLUDES:

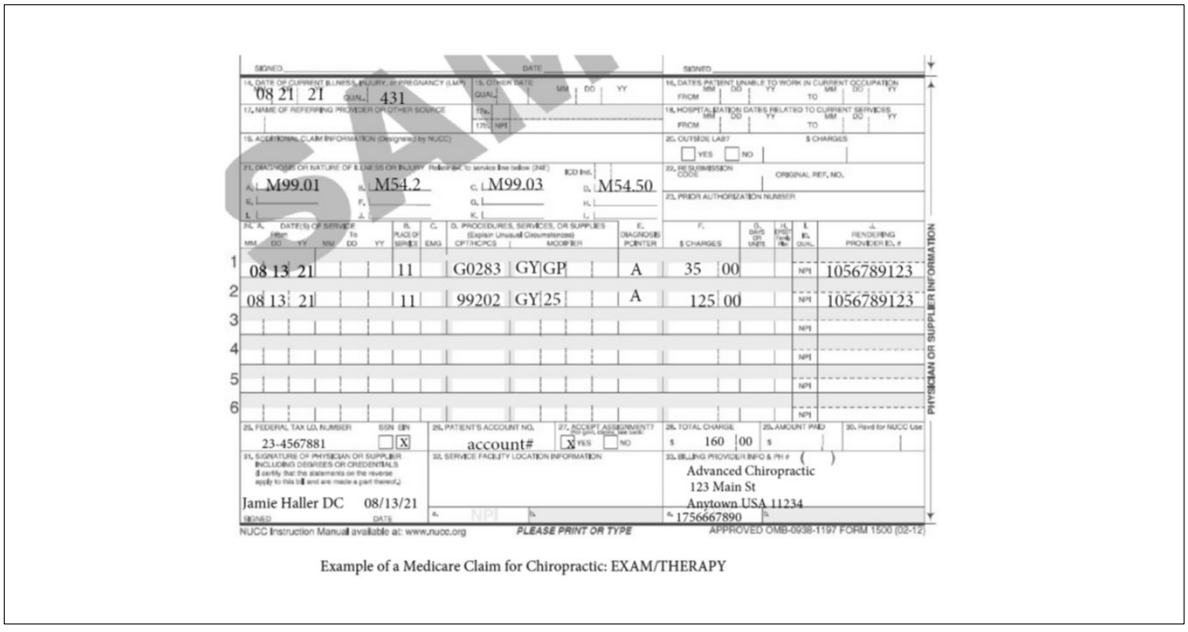
- EXAMS
- XRAY
- THERAPY
- ACUPUNCTURE
- MASSAGE
- DECOMPRESSION
- LASER

YOU ARE NOT REQUIRED TO BILL MEDICARE FOR NON COVERED SERVICES

SOME PATIENTS WITH TRUE SECONDARY PLANS MAY HAVE COVERAGE FOR CERTAIN PROCEDURES NOT COVERED UNDER MEDICARE B

IN THAT CASE, BILL MEDICARE B AND ADD –GY MODIFIER TO THE NON COVERED SERVICES. CLAIM WILL DENY TO PATIENT RESPONSIBILITY AND SECONDARY CLAIM CAN BE BILLED

63



Example of a Medicare Claim for Chiropractic: EXAM/THERAPY

64

BILLING MEDICARE ADVANTAGE PLANS

- Understand your contracts: Are you IN or OUT of Network with the MA plan?
- ALWAYS verify coverage and benefits
- NOTIFY patient in advance if you are OON and there are no benefits
- Most MA Plans follow Medicare Guidelines, some have expanded coverage
- Some MA plans do not honor the AT modifier

65

THE LIFE OF A CLAIM

Starts off as Raw Data

Data Transferred to Claim Form

Claim Transmitted/Filed

Claim Received by Insurance Co.

Claim Processed

Claim Paid, Denied or Delayed

Claim Appealed (if not Paid)

66

GARBAGE IN…GARBAGE OUT

- A key to successful claims is the accuracy of the data that will be submitted to the insurance company
  - Accurate demographics
    - Patient information
    - Insurance information
    - Provider information
  - Accurate coding
    - CPT/HCPCS
    - Modifiers
    - Dx Codes

67

SCRUBBING THE CLAIMS

- FILING THE CLAIM
  - PM Software runs a claims error check
    - Fix any errors before sending out for processing.
  - Once the claims are downloaded, they are either transmitted to a CLEARINGHOUSE for processing, directly to the carrier for processing, or printed on a paper CMS1500 form.
  - MEDICARE claims are filed electronically

68

Central Location for the download, sorting and sending of electronic claims. With a clearinghouse there is no need to send claims to each individual carrier

Clearinghouse will "SCRUB" claims for errors. Report will be available, billing rep must review and fix any claims rejected at the clearinghouse (Level 1)

Claims approved will be sent to carriers. If carriers find errors they will reject claim back to clearinghouse (Level 2)

Clearinghouse can receive EOB's (Remits) for printing and posting

Clearinghouse can receive 835 remits for auto posting to PM system

Very important that reps visit clearinghouse for reports, etc.

Level 1 Rejections are not considered to ever be "Billed". Level 1 claims not fixed can be in danger of timely filing denials.

THE CLEARINGHOUSE

69

A claim is not considered to be billed until it has been ACCEPTED by the payer

Unbilled claims are subject to timely filing rules (anywhere from 60 days to 1 year from date of service)

IMPORTANT!

70

MEDICARE TIMELY FILING

MEDICARE HAS TIMELY FILING RULES OF 1 YEAR FROM DATE OF SERVICE

71

14 BUSINESS DAYS FROM THE DATE IT IS ACCEPTED FOR ADJUDICATION

MEDICARE PROCESSING TIME –ELECTRONIC CLAIMS

72

MEDICARE CLAIMS INVESTIGATIONS

73

MEDICARE PHONE CONTACT

PALMETTO GBA

CUSTOMER SERVICE LINE: **Call 1-855-696-0705 (Toll Free) 8:00-4:30 est**

NOVITAS SOLUTIONS

CUSTOMER SERVICE LINE: **Call** 877-235-8073 **(Toll Free) 8:00-4:00 est**

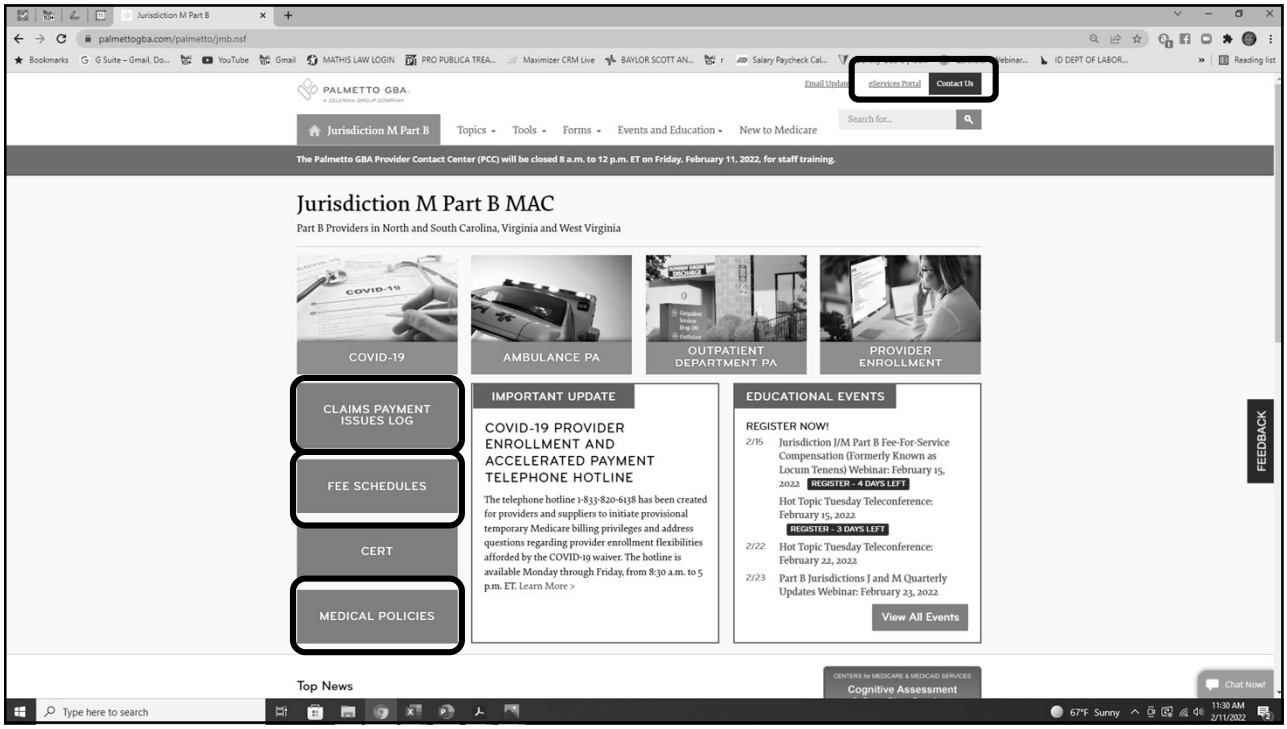
74

MEDICARE PROVIDER PORTALS

PALMETTO GBA – E-SERVICES PORTAL

NOVITAS SOLUTIONS - NOVITASPHERE

75



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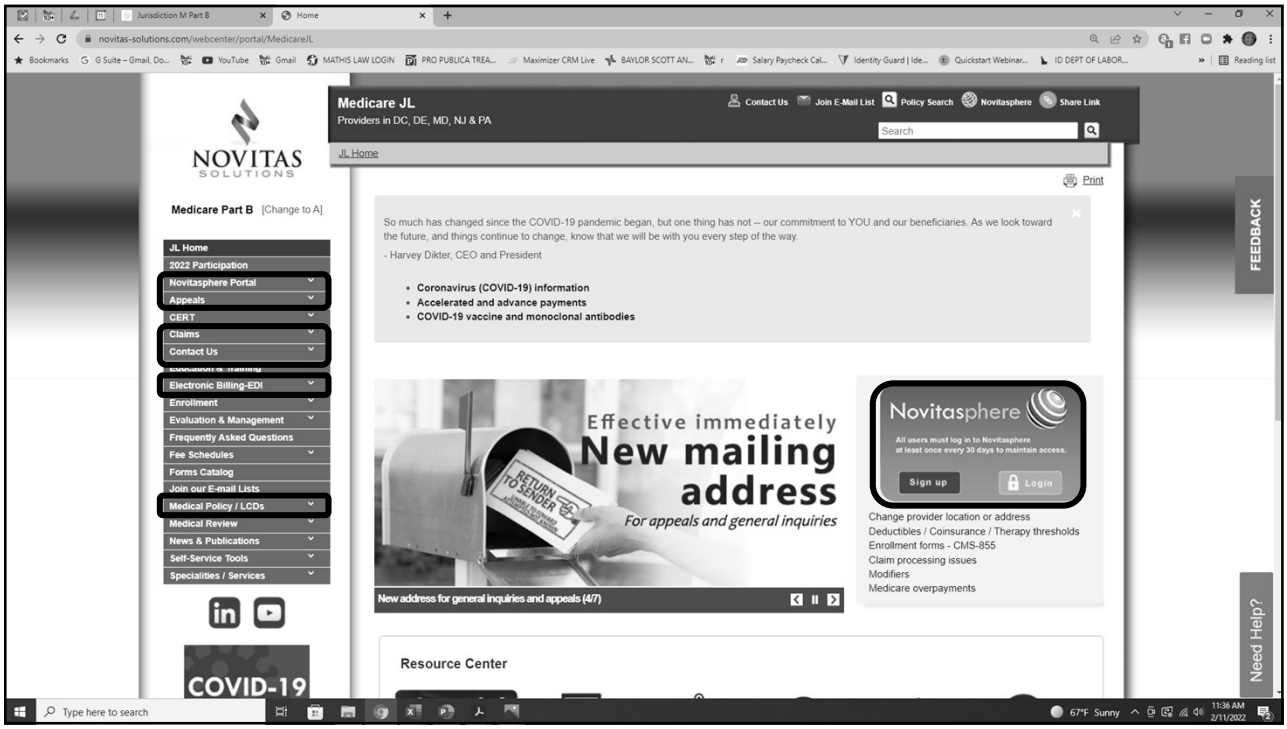


77

HOW CAN PALMETTO GBA E-SERVICES PORTAL AND NOVITASPHERE HELP ME?

- ELIGIBILITY AND BENEFITS
  - Does Patient have Medicare B or MA plan?
  - Is MCR Secondary?
  - Have they met their Part B Deductible?
- CLAIM STATUS
- FIND EOB'S
- REDETERMINATIONS – 1ST LEVEL OF APPEAL
- MEDICAL CLAIMS ATTACHMENTS

78

Medicare Parts A & B Appeals Process

79

REOPENINGS

Types of Reopenings

Clerical Error Reopenings

The Centers for Medicare & Medicaid Services (CMS) defines clerical errors (including minor errors or omissions) as human or mechanical errors on the part of the party or the contractor, such as:

- Mathematical or computational mistakes
- Transposed procedure or diagnostic codes
- Inaccurate data entry
- Misapplication of a fee schedule
- Computer errors
- Denial of claims as duplicates which the party believes were incorrectly identified as a duplicate
- Incorrect data items, such as provider number, use of a modifier or date of service

80

Claim Corrections

RTP = RETURN TO PROVIDER

- The claim correction process only applies to RTP claims. A claim correction may be submitted online via the Direct Data Entry (DDE) system.
- To access RTP claims in the DDE Claims Correction screen, select option 03 (Claims Correction) from the Main Menu and the appropriate menu selection under Claims Correction (21 – Inpatient, 23 – Outpatient, 25 – SNF)
- RTP claims remain in this location (TB9997) and are available for correction for 180 days
- RTP claims are not finalized claims and do not appear on your Remittance Advice (RA). Therefore, correct the claim in DDE (xx7). Remember you cannot correct a medically denied line. You must leave those as non-covered and make necessary corrections. Once the claim processes, you may appeal any denied lines.

CORRECTIONS

(CLAIM REJECTED – BILLING SUBMISSION ERRORS)

81

Appealing Medicare Decisions

Medicare FFS has 5 appeal process levels:

Level 1 - MAC Redetermination

THROUGH YOUR MEDICARE PORTAL

Level 2 - Qualified Independent Contractor (QIC) Reconsideration

Level 3 - Office of Medicare Hearings and Appeals (OMHA) Disposition

Level 4 - Medicare Appeals Council (Council) Review

Level 5 - U.S. District Court Judicial Review

Make all appeal requests in writing.

82

First Appeal Level: MAC Redetermination

A redetermination is the first appeal level after the initial claim determination.

Table 1. Redetermination FAQs & Answers

Question	Answer
When must I file a request?	You must request a redetermination within **120 days** from the date you got the Electronic Remittance Advice (ERA) or Standard Paper Remittance (SPR) Advice that lists the initial determination. The receipt date is presumed to be 5 days after the notice date, unless there's evidence the determination, decision, or notice wasn't received within that time.

83

How long does it take to decide?	MACs generally issue a decision within **60 days** of the redetermination request receipt date. Your MAC tells you its decision via a Medicare Redetermination Notice (MRN), or if they reverse the initial decision and pay the claim in full, you get a revised ERA or SPR.

84

Appeal Process Summary

Table 6. Appeal Process Summary

Level	Review Process Summary	Who decides?	When must I file a request?	How long does it take to decide?	AIC	Forms
First Level – MAC Redetermination	Document initial claim review determination	MAC	Up to 120 days after you get initial determination	60 days	No	CMS-20027 CMS-20031
Second Level – Qualified Independent Contractor (QIC) Reconsideration	Document redetermination review; send any missing appeal evidence	QIC	Up to 180 days after you get the Medicare Redetermination Notice (MRN)	60 days	No	CMS-20033
Third Level – Office of Medicare Hearings and Appeals (OMHA) Disposition	May be an interactive hearing between parties or an on-the-record review	Administrative Law Judge (ALJ) or attorney adjudicator	Up to 60 days after you get the QIC decision notice or after QIC reconsideration expiration time frame if you don't get a decision	90 days if appealing a QIC reconsideration decision or dismissal or 180 days if appeal was escalated to OMHA	Yes	OMHA-100 OMHA-100A OMHA-104
Fourth Level – Medicare Appeals Council (Council) Review	Document ALJ's review decision (you may request oral arguments)	Council	Up to 60 days after you get the OMHA's disposition notice or after expiration time frame if you don't get a decision	90 days if appealing an OMHA disposition or dismissal or 180 days if ALJ review time expired without an ALJ decision	No	DAB-101
Fifth Level – U.S. District Court Judicial Review	Judicial review	U.S. District Court	Up to 60 days after you get the Council decision notice or after Council expiration time frame if you don't get a decision	No statutory time limit	Yes	No HHS form available

85

Set up Provider Portal Access

Research Policy for Reopenings/Corrections and Appeals

Will be different than Medicare B

Will be different based on each individual payer

APPEALS FOR MEDICARE ADVANTAGE CLAIMS

86

ABN'S (ADVANCE BENEFICIARY NOTICES) are used to inform patients that certain services and procedures may not be covered, and they may be financially liable.

ABN's are used in all practice settings, with all types of insurance companies, including Medicare B, Medicare Advantage, and Commercial Payers.

Failure to Notify patients in advance that a service might not be covered could result in the provider having to write off the entire claim, if not paid

ABN'S

87

THE MEDICARE ABN

BACKGROUND

You must issue an ABN:

•When an item or service is not reasonable and necessary under Medicare Program standards, including care that is:

- Experimental and investigational or considered "research only"
- **Not indicated for diagnosis or treatment in this case**
- Not considered safe and effective
- More than the number of services Medicare allows in a specific period for the corresponding diagnosis

Excerpt from MLN: **ICN MLN909183 July 2020**

88

Generally, CMS recognizes three events known as "ABN Triggering Events" where a supplier must furnish an ABN to a beneficiary prior to furnishing items or services. These three events are:

a) Initiation – At the beginning of a new patient encounter, start of a plan of care, or beginning of treatment, a supplier must issue an ABN to the beneficiary if the supplier knows or reasonably believes that Medicare is likely going to deny payment.

b) Reduction – A supplier must issue an ABN to a beneficiary if there is a reduction in the patient's care plan and the patient would like to continue receiving care that is no longer considered medically reasonable or necessary.

c) Termination – A supplier must issue an ABN to a beneficiary if there is a discontinuation of certain items or services and the beneficiary would like to continue receiving care that is no longer medically reasonable and necessary.

89

CHANGES TO ABN RULES AS OF 10/14/21

- Beginning on October 14, 2021 ("Effective Date"), suppliers must use the updated and revised ABN guidelines found in Chapter 30, Section 50 of the *Medicare Claims Processing Manual*. A few of the key provisions that were revised include:
- (i) the events that trigger the furnishing of an ABN,
- (ii) general notice preparation requirements,
- (iii) the furnishing of ABNs to dual eligible individuals, and (iv) the period of effectiveness.

90

Prior to the July 14, 2021, revisions, ABNs were effective for up to one year. However, as of the Effective Date of revised provisions, **a valid ABN will remain effective indefinitely** so long as there is no change in:

- the patient's plan of care;
- the beneficiary's health status that would require a change in treatment for the non-covered condition; and/or
- there are changes to the Medicare coverage guidelines for the items or services in question.

If any of the above-mentioned criteria changes during the course of treatment, the supplier must issue a new ABN to the beneficiary. If the beneficiary is receiving items or services that are repetitive or continuous in nature, the supplier may issue another ABN after the first year, but it will no longer be required to do so.

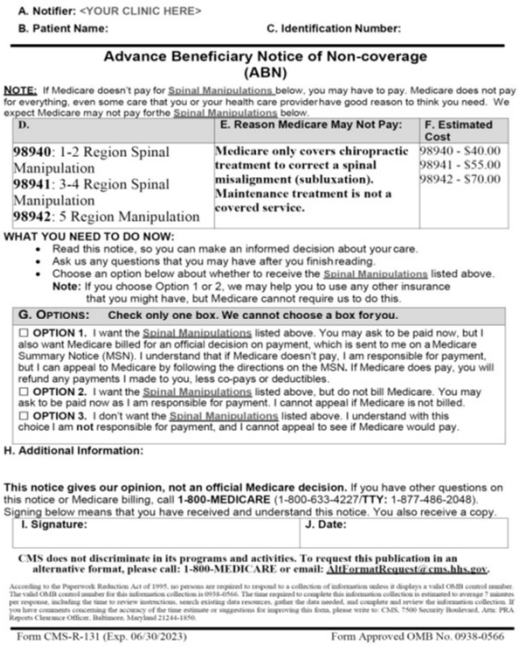
91

THE MEDICARE ABN AND CHIROPRACTIC

- ONLY MEDICARE PART B
- ONLY FOR SPINAL MANIPULATIONS
- OTHER SERVICES UNDER A VOLUNTARY ABN
- USE THE MOST CURRENT FORM
- ISSUE ABN WHEN YOU BELIEVE MEDICARE WILL STOP PAYING
- ISSUE NEW ABN IF THERE IS A NEW TX PLAN/NEW DX
- NO LONGER NECESSARY TO FILL OUT ANNUALLY (AS OF OCT 15TH 2021)

92

92



A. **Notifier:** <YOUR CLINIC HERE>

B. **Patient Name:** C. **Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for Spinal Manipulations below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the Spinal Manipulations below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
98940: 1-2 Region Spinal Manipulation **98941**: 3-4 Region Spinal Manipulation **98942**: 5 Region Manipulation	**Medicare only covers chiropractic treatment to correct a spinal misalignment (subluxation). Maintenance treatment is not a covered service.**	98940 - $40.00 98941 - $55.00 98942 - $70.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the Spinal Manipulations listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the Spinal Manipulations listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the Spinal Manipulations listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the Spinal Manipulations listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

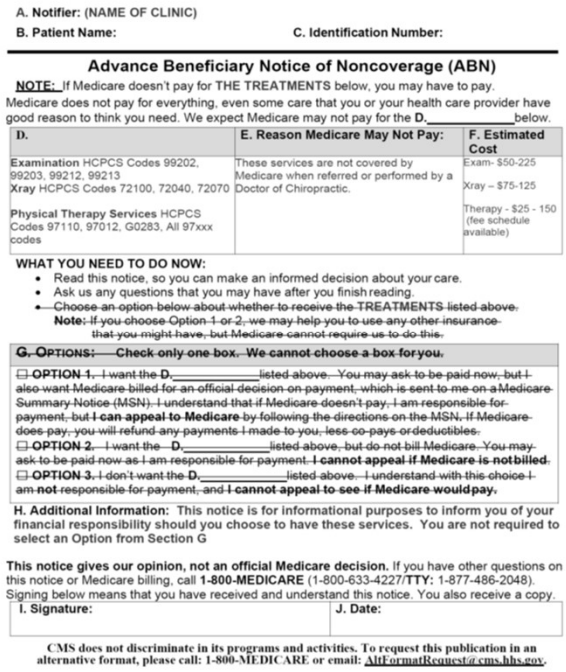
Form CMS-R-131 (Exp. 06/30/2023) Form Approved OMB No. 0938-0566

EXAMPLE OF A CHIROPRACTIC ABN

REVIEW WITH PATIENT

DO NOT TELL THEM WHAT OPTION TO CHOOSE!

93



A. **Notifier:** (NAME OF CLINIC)

B. **Patient Name:** C. **Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for THE TREATMENTS below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Examination HCPCS Codes 99202, 99203, 99212, 99213 **Xray** HCPCS Codes 72100, 72040, 72070 **Physical Therapy Services** HCPCS Codes 97110, 97012, G0283, All 97xxx codes	These services are not covered by Medicare when referred or performed by a Doctor of Chiropractic.	Exam- $50-225 Xray – $75-125 Therapy - $25 - 150 (fee schedule available)

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- ~~Choose an option below about whether to receive the TREATMENTS listed above.~~
  ~~**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.~~

~~G. OPTIONS: Check only one box. We cannot choose a box for you.~~

~~☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.~~

~~☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**~~

~~☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**~~

H. Additional Information: This notice is for informational purposes to inform you of your financial responsibility should you choose to have these services. You are not required to select an Option from Section G

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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EXAMPLE OF A VOLUNTARY CHIROPRACTIC ABN

NOTIFIES PATIENTS OF SERVICES THAT ARE NOT COVERED BY MEDICARE

INFORMATIONAL ONLY, PATIENT DOES NOT NEED TO CHOOSE ANY OPTIONS

94

ABN'S FOR NON-PAR PROVIDERS AND DUAL ELIGIBLE PATIENTS (Medicare/Medicaid) ARE FILLED OUT SLIGHTLY DIFFERENTLY. EXAMPLES AND GUIDELINES AVAILABLE ON REQUEST.

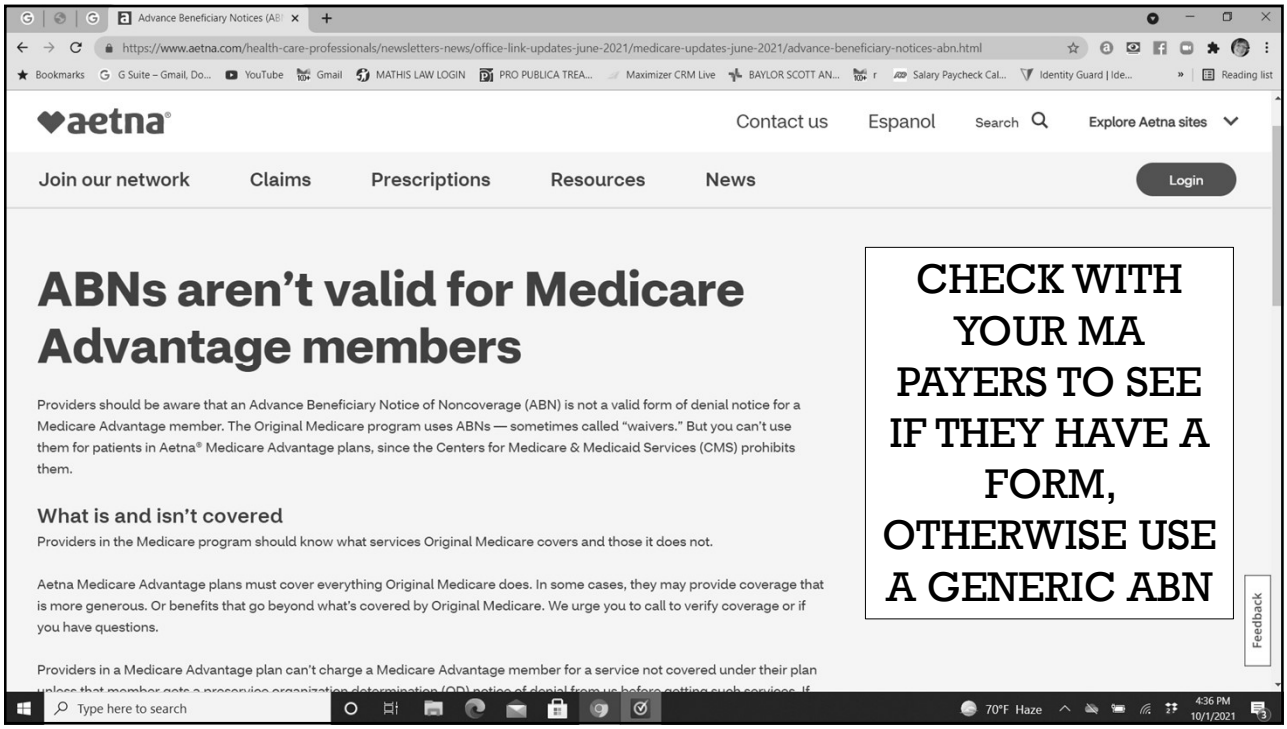
SEND EMAIL TO INFO@GOLDSTARMEDICAL.NET

95

WHAT ABOUT MEDICARE ADVANTAGE PLANS?

- DOCUMENTATION REQUIREMENTS ARE THE SAME
- CODING REQUIREMENTS MAY BE DIFFERENT
  - Some MA plans do not recognize AT mod.
  - Some MA plans have expanded coverage
- MA plans do not recognize the Medicare ABN. They may have one of their own, or use a generic ABN

96



CHECK WITH YOUR MA PAYERS TO SEE IF THEY HAVE A FORM, OTHERWISE USE A GENERIC ABN

97

YOUR CLINIC NAME YOUR CLINIC ADDRESS YOUR CLINIC CITY/STATE/ZIP

Advance Notice of Non-Covered/Experimental Services

Patient Name:	Member ID Number:
Ordering Provider Name and NPI:	
Name of Provider(s) Rendering Services:	

Your provider has recommended that you receive the following medical service(s) / item(s)

Services/Items:	Estimated Costs:
SPINAL MANIPULATION CPT CODES 98940, 98941 AND 98942	$45, $55, $75
Services/Items:	Estimated Costs:
Additional Information:	
Medicare only covers chiropractic treatment to correct a spinal misalignment (subluxation). Maintenance treatment is not a covered service.	

We,_____(name of provider rendering services), will submit a claim to your health plan, but expect that your health plan may not pay for these service(s) / item(s) because your health plan will determine that the services are:

- Not medically necessary benefits under your insurance plan; or
- Investigational under your health plan's medical policy guidelines.

The fact that your health plan may not pay for a particular item or service does not mean that you should not receive it. Please feel free to ask us to explain why your health plan may decide that the service(s) or item(s) are not medically necessary or are investigational, and why we recommend that you receive the service(s) / item(s).

Because_____(name of provider rendering services) is contracted with your health plan, if the claim is denied for the reasons listed above, we are not allowed to bill you for the service unless you agree to pay us. The purpose of this form is to help you make an informed choice about whether you want to receive these service(s) / item(s), knowing in advance that you might have to pay for them yourself.

Choose one option, check one box, then sign and date.

☐ **YES. I want to receive these items or services. I understand that:**
✓ My health plan will not decide whether to pay unless I receive these items or services and my provider submits a claim to my health plan.
✓ My health plan will decide whether to pay based on the claim my provider submits, any supporting medical records, the terms of my benefit plan, and current My health plan medical policy guidelines.
✓ If My health plan denies the claim as not medically necessary or investigational, or I exceed the number of visits authorized by my health plan, I will have to pay for these services myself, and I agree to be personally and fully responsible for payment.
✓ If My health plan does pay the claim, you will refund to me any advance payments I made to you that are due to me.
✓ I can appeal My health plan's decision to deny payment of the claim.

☐ NO. I have decided that I do not wish submit further claims to my insurance company if they are either not medically necessary or investigational under my benefit plan, or if I have exceeded the number of visits authorized by my health plan. I understand that I will be afforded the option to pay cash for these services at a time of service discount.

☐ NO. I do not wish to have these services performed.

Signature of patient or person acting on patient's behalf _____ Date _____

If a payer specific ABN is not available, use a generic form.

Can be used with MA and Commercial Payers for a variety of scenarios

98

QUESTIONS?

CONCERNS?

NEED HANDOUTS?

NEED FORMS?

NEED ADVICE?

NEED HELP?

BILLING SERVICES
TRAINING
CREDENTIALING
CONSULTING
COMPLIANCE

UVCA MEMBER BENEFIT

- Call Gold Star Medical Business Services for a **Complimentary Consultation**
- Phone: 208-818-4995
- Email: CELDRIDGE@goldstarmedical.net
- Visit website: www.goldstarmedical.net
- Facebook: www.facebook.com/goldstarmedical

99

THANK YOU FOR YOUR ATTENDANCE!

100