

## **Medicare Article: Part I Understanding Medicare**

Medicare is the largest purchaser of managed care and the largest health payer in the country. Supplying coverage for over 43 million Americans and growing with the aging of the boomer population, the impact it has in the health arena cannot be denied.

The following series of articles have been prepared by the Association of Chiropractic Colleges Post-graduate Subcommittee to serve doctors in the field and to address the concerns outlined in the 2005 OIG report.

According to the Office of the Inspector General, a whopping 94% of claims submitted by chiropractors are missing required elements in the documentation with a detailed breakdown as follows:

<b>Element</b>	<b>Percentage of Documentation Errors by Chiropractors</b>
Evaluation: Improper or missing	34%
Diagnosis: Improper or missing	33%
Treatment plan: Insufficient	83%
Medical necessity not shown or miscoded	67%
Contraindications not checked	66%

A rallying of the profession to remedy this problem is crucial to maintaining our providership privileges and our position in the health community. While Colleges are focusing even more education on this topic in the core curriculum, doctors in the field must find resources to help them ensure compliance as well.

*“Where Medicare goes, the world will follow.”*

Medicare was first adopted in 1965 with two-part coverage. Part A-Hospital and Part B-Medical were both administered by HCFA (now CMS) . Chiropractic wasn't included until 1972. Two additional parts have also been added to the plan. Part C-Managed Care, and Part D-Prescription Drugs. Chiropractic works under Parts B and C as appropriate.

What many don't understand is that the Social Security Administration funds Part A. Funding from the Federal Government supports Part B. Funding for Part B is always at risk of being revoked if given just cause. A professional documentation epidemic would certainly fit the bill. With all carriers typically following the lead of Medicare, such a revocation could result in catastrophic damage to chiropractic practitioners and to the profession as a whole.

### **The Top 10 Misconceptions about Medicare**

(Adapted from “Medicare Made Simple” notes as presented by Susan A. McClelland, BS, CCA, FICC for the Association of Chiropractic Colleges May 3, 2007).

- 1. Rumor: There is a 12 visit cap on chiropractic services.**

**Truth:** There are no caps in Medicare for chiropractic at this time. However, there may be periodic review screens, or intervals at which the carrier may require a review of documentation to allow continued service.

**2. Rumor: I can treat Medicare patients without being registered.**

**Truth:** It is illegal to treat Medicare patients and not be registered with Medicare. You may choose to be a ‘participating’ or ‘non-participating’ provider, but you must register. If you treat a Medicare patient with a spinal CMT code, you MUST submit a claim.

**Note:** Starting May 23, 2007 all HIPAA covered entities, except small health plans, should begin using the National Provider Identifier (NPI). Under the National Provider Identifier Regulation published on January 23, 2004, a health care provider who is a covered entity is required to obtain an NPI by May 23, 2007. This is separate from registering for Medicare, but required. If you don’t yet have a number, visit <https://nppes.cms.hhs.gov> on the web or call 1-800-465-3203 to request a paper application.

**3. Rumor: If you are a non-participating provider (non-par), you do not have to worry about billing Medicare.**

**Truth:** Being non-par does not exempt you from having to bill Medicare. ALL Medicare-covered services must be billed to Medicare or the provider could face penalties.

**4. Rumor: If you are a non-par provider, you will never be audited or have claims reviewed.**

**Truth:** Any Medicare claim submitted can be audited/reviewed despite provider status. The status of the physician does not affect the probability of this occurring.

**5. Rumor: Non-par providers do not have the same documentation requirements as par providers.**

**Truth:** Chiropractic care has documentation requirements to show medical necessity. The participation status of the provider is irrelevant.

**6. Rumor: You can ‘opt out’ of Medicare.**

**Truth:** Opting out is NOT an option for Doctors of Chiropractic. If you treat Medicare patients, you must register as ‘participating’ or ‘non-participating’. If you don’t want to deal with Medicare, then don’t treat Medicare patients. It is illegal to treat Medicare patients and not submit a claim.

**7. Maintenance care is not a covered service under Medicare.**

**Truth:** Spinal manipulation is a covered service under Medicare, no matter which phase of care you may in; however, maintenance care is not REIMBURSABLE. Acute, chronic, and maintenance adjustments are all ‘covered’, but only acute and chronic services are considered active care and may, therefore, be reimbursed.

**8. Rumor: An ABN (Advance Beneficiary Notice) should be signed once for each patient and it will apply to all services, and all visits.**

**Truth:** The decision to deliver an ABN must be based on a genuine reason to expect that Medicare will deny payment for the service due to lack of medical necessity. ABNs are for Medicare-covered services only. You should use it for a “maintenance care” adjustment; you would not use it to make the patient liable for therapy services. A separate NEMB form could be used for such adjunctive services (Notice of Exclusions from Medicare Benefits.) Note that this was true at the time of writing this article. This area is slated for change in the next few months so keep a close eye on this requirement.

**9. Rumor: Medicare requires unreasonable record keeping and documentation to receive reimbursement.**

**Truth:** Medicare has specific documentation requirements, but nothing extraordinary. Whether a patient is a Medicare patient or not, chiropractors should be exercising specific standards in their chart notes with thorough documentation for every encounter.

**10. Rumor: Chiropractors can make special offers to Medicare patients.**

**Truth:** Inducements of any kind are strictly forbidden for Medicare patients. Free exams, x-rays, or even chicken dinners could lead doctors to accusations of fraud. An exception to this rule is if you waive a portion of the patient’s fee due to documented financial hardship. “Smallness” is another exception; this is where you can write off the amount being collected if it is less than your cost to try to collect it. This would apply to *very* small dollar amounts such as \$2.86.

## **Medicare Article: Part II Essentials of Documentation**

This article is the second of a series of articles that have been prepared by the Association of Chiropractic Colleges Post-graduate Subcommittee to serve doctors in the field and to address the concerns outlined in the 2005 OIG report which stated that 94% of claims submitted by chiropractors are missing required elements in the documentation.

### **Essentials of Documentation**

(Adapted from “Medicare Made Simple” notes as presented by Susan A. McClelland, BS, CCA, FICC for the Association of Chiropractic Colleges May 3, 2007).

Medicare has specific requirements for documentation, but nothing extraordinary. Whether a patient is covered by Medicare, or not, all chiropractic encounters should be represented with appropriate, specific record-keeping that adheres to a basic standard. Documentation should contain required elements and should be consistent, accurate, legible, indelible, chronological, dated, signed/initialed, and contemporaneous.

#### **Quick Tips:**

- If you use medical shorthand, be sure to use and understand standard abbreviations and symbols. Never ‘make up’ abbreviations.
- Appropriate documentation on file should include intake forms/questionnaires, initial exam report, daily visit SOAPs that include identification of subluxation via x-ray or PART, follow up exams, and waivers. Documentation must be able to support ‘medical’ necessity for chiropractic care.
- Be careful of computer-generated notes. Notes must be thorough and specific to each patient and each encounter.

#### **Identifying the subluxation.**

Subluxation must be demonstrated by x-ray or by PART in all of your initial and subsequent notes. Technically, this is not true... If you utilize x-ray, the films must be reasonably proximate (within 12 months prior to or three months after the initiation of care). Exceptions may be made if the condition is chronic/permanent. A CT/MRI may be accepted. If you utilize the PART method, you must demonstrate a subluxation based on physical examination. Two of the four criteria are required, and one of them must be asymmetry/misalignment or range of motion abnormality.

**Pain/tenderness** (Include location, quality, intensity. Findings can be identified via: observation, percussion, palpation, provocation, pain scales, alogmeters, pain questionnaires, etc.)

**Asymmetry/misalignment** (Sectional or segmental level. Findings can be identified via: observation of posture/gait, static palpation, imaging, etc.)

**Range of motion abnormality** (Changes in active, passive, and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility. ROM findings can be

identified via: motion palpation, observation, stress diagnostic imaging, ROM measurements, etc.)

**Tissue/tone changes** (Changes in the soft tissues including skin, fascia, muscle, and ligament. Findings may be identified via: observation, palpation, use of instrumentation, tests for length and strength, etc.)

Always back up findings with objective data. And remember that no one will complain if you utilize both x-ray and PART to demonstrate your case!

### **Initial Visit Must-Have's**

The initial visit should include no less than a patient history, description of the presenting complaint, evaluation findings, diagnosis, treatment plan, and date of initial visit.

**History:** Statement of health, past health history, social/family history, description of the presenting complaints and any secondary complaints.

**Presenting complaint:** Symptoms, mechanism of trauma, quality and character of the pain, onset, duration, intensity, frequency, location, and radiation of symptoms, aggravating/relieving factors, prior interventions, treatments, and medications.

**Evaluation:** Physical examination and evaluation of the musculoskeletal/nervous system. Document everything you do and detail your findings.

**Diagnosis:** The primary diagnosis must be subluxation, including the level. The description must include reference to the condition of the spinal joint involved or to the direction/position assumed by the named joint. The secondary diagnosis would refer to the NMS condition and should be directly/causally related to the subluxation noted.

**Treatment plan:** Include the recommended level of care with duration and frequency of visits, specific treatment goals, and objective measures to evaluate treatment effectiveness. Always include the date of the initial treatment and sign it!

Sample treatment plan: 05-05-06 CMT and adjunctive modalities daily for 1 week and 3x/wk for the following 2 weeks. Re-eval at that time; L MRI may be indicated. Off work 2 wks. Home care: Cryo q 2 hrs x 15 mints; avoid strenuous activity; LS supports to be worn when standing. Short-term goals: Minimize pain (<3) and spasm; increase pain-free LS flexion (>45 degrees). Long-term goals: restore ability to tie shoes w/o pain, sit/stand for prolonged periods (>2 hrs.), and get in/out vehicles w/o difficulty; return normal sleep patterns. *Dr. SIGNATURE.*

### **Subsequent Visits**

Subsequent visits should be documented and should include no less than the following: subjective comment on patient's progress and changes since last visit, physical exam findings including changes since last visit, and documentation of the treatment given on the day of the visit (don't just refer back to the plan from the initial visit without also giving today's findings!)

- S: Review of chief complaint, note any changes since the last visits, system review if relevant (any surgeries, illness, trauma, or medications since last visit?)
- O/A: Physical/regional exam. Examine the area of the spine involved in the diagnosis and note findings. Assess change in the patient's condition since the last visit. Evaluate the treatment for effectiveness. (Note, listings and type of technique are not currently required by CMS or CPT in reporting; however, for the thoroughness of the record we'd recommend these details.)
- P: Document the treatment given on the day of the visit and any adjunctive therapy (if used).

Sample subsequent visit note:

05-15-06: patient notes diminished intensity/frequency of LBP. VAS decreased to 4/10. Overall lumbar paraspinal spasm/tenderness bilaterally, but decreased since last visit. Joint fixation at L4-L5 and right SI. Condition resolving. L5 and RSI adjusted with side posture. Continue treatment plan as prescribed at initial visit on 05-05-06. Return Tuesday. *Dr. Signature*

**Self -Test**

As you review your records, ask yourself the following questions, 'Does the record show...':

- ...a significant NMS condition?
- ...precise subluxation(s) documented by physical exam or x-ray?
- ...a complaint consistent with the subluxation levels found?
- ...noted vital signs?
- ...a past health history?
- ...a check for contraindications?
- ...noted quality and intensity of chief complaint?
- ...noted aggravating and relieving factors?
- ...the physical exam substantiating the condition and the subluxation?
- ...a primary diagnosis of subluxation and a secondary NMS condition caused by the subluxation?
- ...a treatment plan with specific goals?
- ...notations for subsequent changes?
- ...the adjustment clearly recorded in the record as being accomplished?
- ...notations on the effectiveness of treatment that would qualitatively and quantitatively substantiate the need and frequency of treatment?
- ...the adjustment is for acute, chronic, or maintenance care along with appropriate ABN documentation?

## **Medicare Article: Part III**

### **Filling out the Health Insurance Claim Form**

A bulk of Medicare denials stem, quite simply, from filling out the Health Insurance Claim Form incorrectly. It is important that offices follow a systematic process for filing claims. It is also crucial for our profession that all services are documented showing necessity in your records, and that you list all services on the claim form even if it is viewed as non-covered and/or non reimbursable by Medicare.

This is important because the chiropractic profession must have data if, in the future, we lobby for more covered services. If we haven't utilized/reported/performed the services in the past then why should we expect coverage in the future? All services, covered or not, should be documented completely in your records. Complete submissions will help ensure the path that chiropractic is on will continue to be a progressive one. A quick reminder that non-covered service listings will require a GY modifier.

### **Filling out the Health Insurance Claim Form**

#### **Top 13 Quick Tips**

For even more detailed information on filling out the health insurance claim form please visit [http://www.nucc.org/images/stories/PDF/claim\\_form\\_manual\\_v2-1\\_3-07.pdf](http://www.nucc.org/images/stories/PDF/claim_form_manual_v2-1_3-07.pdf).

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**Box 1a:** Reproduce the HICN as found on the Medicare card. This is normally a series of 9 numbers and a letter. This series of characters should be reproduced exactly on the form, without using spaces or hyphens, or your claim will be sent back to you.

**Box 2:** Reproduce the name as found on the Medicare card. You may know the patient as Bob Jones, but his real name may be Melvin Robert Jones. If you put Bob on the claim form, and the Medicare card has him listed as Melvin Robert, your claim will be denied.

**Box 11:** Write "NONE" (if Medicare is primary) or enter the primary insurance policy #. You must check to MAKE SURE if Medicare is primary and that you aren't dealing with PI, WC, or primary Employer Health Insurance.

**Box 14:** Insert the date of first treatment or date of exacerbation. Note: the date of first treatment is NOT the first time they entered your office, but rather should be the first visit for this occurrence of the current condition.

**Box 17/17a:** Insert the referring/ordering physician's name and NPI. This could be you or someone else. Fill it out for x-ray codes, labs, or consults.

**Box 19:** X-ray date, if used to identify subluxation.

**Box 24E:** Diagnosis pointer. Only put one number in this column!

**Box 24F:** Charges (may not be more than Limiting Charge, if non-par provider not accepting assignment).

**Box 24 I/J:** Provider NPI.

**Box 32:** Place of service. This must be the physical address of where the services were rendered (not a PO Box).

**Box 21 ICD-9:** The primary code must be a subluxation (739.\*). Secondary codes should be NMS codes from an approved list.

**Box 24D CPT Coding:** Only put one service per line! Spinal CMT coding is covered (98940/98941/98942). All other services are non-covered. Don't forget to use the correct modifiers, and that EMS should be coded as G0283 instead of 97014 (so it will be denied as non-covered vs. invalid.)

**Modifiers: Don't forget them!** The five modifiers used in chiropractic care are listed below.

- -GY : Non-covered service
- -GA : properly delivered ABN
- -GZ : 'Oops'. Use this on the rare occurrence that you should have gotten an ABN but, for some reason, did not.
- -GP : Therapy
- -AT : Active care (acute and chronic) spinal CMT.