Medicare Updates Part 2

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Tracy Cole, D.C., Bio

- CCA representative to Noridian Contractor Advisory Committee for California
- Member, ACA Medicare Committee
- Member, CCA Managed Care and Insurance Committee
- Participant on CCA Member Resource Center panel
- Past President CCA 2012-2013
- ACA Northern California Alternate Delegate

Who is David Martinez?

- Owner/Operator of Accurate Medical Billing and Audit
- Started as a Claims Examiner with Aetna 1988
- Certified Professional Coder- Professional CPC-P)
- Certified Professional Coder- Instructor (CPC-I)
- Certified HIPAA Professional (CHP)
- Certified Chiropractic Professional Biller (CCPB)
- Certified HealthCare Claims Auditor (CHCA)
- Certified Medical Reimbursement Specialist (CMRS)
- Certified HIPAA Auditor (CHP)
- Co-Chair of the CCA Managed Care and Insurance Committee

ACCURATE MEDICAL BILLING & AUDIT
When Experience Counts & Quality Matters

LCD ICD-10 Code Categories

Group 1 Subluxation codes

Group 2 : Secondary ICD-10-CM Codes

- Category I - ICD-10-CM Diagnosis (diagnoses that generally require short term treatment

Group 3 :

- Category II - ICD-10-Cm Diagnosis (diagnoses that generally require moderate term treatment

Group 4:

- Category III - ICD-10-CM Diagnosis (diagnoses that may require long term treatment)

Mandatory Claim Submission

- Not mandated to treat/see Medicare patients, but once service/procedure provided, must bill
  - Only the 98940-98942 codes
  - Including maintenance therapy if option # 1 is checked on ABN form by the patient
- Not allowed to “Opt-Out” of Medicare
  - If seeing a Medicare patient, you must enroll
- Timely claim filing
  - 12 months from date of service
  - Provider may not bill patient if deadline not met
  - Potentially covered codes (98940/98941/98942)

Medicare Benefit Policy Manual Ch. 15 Section 40

Agreements with Medicare beneficiaries that are not authorized as described in these manual sections and purport to waive the claims filing or charge limitations requirements, or other Medicare requirements, have no legal force and effect. For example, an agreement between a physician/practitioner, or other supplier and a beneficiary to exclude services from Medicare coverage, or to excuse mandatory assignment requirements applicable to certain practitioners, is ineffective. The A/B MAC (B) will refer such cases to the OIG. This subsection does not apply to noncovered charges.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

Medicare Benefit Policy Manual Chapter 15 40.4 - Definition of Physician/Practitioner

For purposes of this provision, the term “physician” is limited to doctors of medicine; doctors of osteopathy; doctors of dental surgery or of dental medicine; doctors of podiatric medicine; and doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the State in which such function or action is performed; no other physicians may opt out.

The opt out law does not define “physician” to include chiropractors; therefore, they may not opt out of Medicare and provide services under private contract.

Par vs. Non-Par Providers

- As a participating (par) provider with Medicare, you agree to bill Medicare and accept assignment of benefits directly from Medicare
- As a non-participating provider (non-par), you can choose to accept assignment or not with each patient. If not accepting assignment, you are allowed to collect directly from the patient up to the allowed limiting charge. A bill must still be sent to Medicare. The patient is reimbursed 80% of that amount by Medicare.
- The limiting charge amount depends on your location of practice as well as whether or not you successfully reported on PQRS. In addition, it also depends on whether you have attested that you have a certified EHR system.

Primary Diagnosis Codes

Manipulation Codes

98940: CMT; spinal, one to two regions

98941: CMT; spinal, three to four regions

98942: CMT; spinal, five regions

Primary ICD-10 Diagnosis Codes

Cervical (including occiput): M99.01

Thoracic: M99.02

Lumbar: M99.03

Sacral (sacrum and coccyx): M99.04

Pelvic (ilium right and left): M99.05

Chiropractic Claim Summary

- Must include the following:
  - Date of service
  - Place of service
  - Procedure code
  - Initial date for this course of treatment
  - Subluxation(s)/regions
    - Primary diagnosis(es)
  - Symptoms(s) or conditions
    - Secondary diagnosis(es)
  - Chiropractor NPI
- Failure to report may result in claim denial

Claim Requirement Highlights 2

- **Item 21** – Diagnosis
  - No decimals or descriptions
  - Must be to highest level of specificity
  - Up to 12 available
- Each region billed <u>requires both diagnoses</u>
  - One primary and corresponding secondary diagnosis
- List clinically significant primary/secondary
  - Document additional diagnoses in clinical record
  - E.g. A = M99.01 (primary) B = M54.2 (second)

Claim Requirement Highlights 3

- **Item 24E**
  - Primary diagnosis (alpha) linked from Item 21
  - Enter one correlated alpha only
- **Item 24J**
  - Individual practitioner NPI
- **Item 33A**
  - Group or Solo NPI
  - 10-digit **numeric** number

Medicare Modifier Review

AT Modifier Active Treatment—Used on Covered Services (Spinal CMT) Only.

Active treatment consists of acute and chronic (active/corrective) care. The –AT is required (as of October 1, 2004) on active treatment 98940, 98941, 98942 and is meant to represent to Medicare that the care was medically necessary (under Medicare guidelines). –AT would never be used on maintenance care. Please make sure you understand the Medicare definitions of acute, chronic, and maintenance care.

GA Modifier

Advance Beneficiary Notice (ABN) on File—Used on Covered Services (Spinal CMT) Only.

The Advance Beneficiary Notice (ABN) is the form that is used when a covered service (spinal manipulation) is expected to be denied due to lack of medical necessity. If the treatment of a Medicare beneficiary is maintenance care, and therefore would be considered not medically necessary and not reimbursable by Medicare, you would have the patient sign an ABN and are required to append the GA modifier.

GZ Modifier

Advance Beneficiary Notice (ABN) NOT on File—Used on Covered Services (Spinal CMT) Only.

Use this modifier when an ABN should have been signed, but wasn't. This modifier is a measure of good faith towards Medicare that you recognize you made an error. Please note that you may NOT collect payment from the patient.

GY Modifier

Non-Covered Service (Services Which Are Statutorily Excluded or Do Not Meet the Definition of Any Medicare Benefit)—Used on All Non-Covered Services (anything NOT spinal CMT).

This modifier is required on all services other than manual manipulation of the spine, including x-rays, extra-spinal CMT, therapy modalities, and exams. Please note that you do not use GY on maintenance care spinal CMT.

GP Modifier

Services Delivered Under an Outpatient Physical Therapy Plan of Care—Used on Therapy Services Only.

This modifier is required on most therapy codes and would be used in addition to the GY modifier (e.g., 97035 GPGY). Please note this does not mean therapy services are reimbursable if delivered by a doctor of chiropractic.

Explanation of Always Therapy Services and their Required Modifiers

In a Medicare Learning Network (MLN) article released last year (12/21/2017), CMS announced that starting on Jan 1, "Always Therapy" services billed must have the appropriate therapy modifier (GN, GO, or GP) appended. CMS has a list of the CPT codes that are considered "Always Therapy" and therefore require a GP modifier – these include 97140, 97012, 97035 and G0283, among several others. These modifiers must accompany the "Always Therapy" service, regardless of what provider type performed the services.

- -GP Services delivered under an outpatient physical therapy plan of care
- -GN Services delivered under an outpatient speech therapy plan of care
- -GO Services delivered under an occupational therapy plan of care.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10176.pdf

Medicare Modifier Quiz

1. You have treated a patient with maintenance care spinal CMT. Is it reimbursable under Medicare?

a) Yes
b) No

b) No

2. You have treated a patient for maintenance care spinal CMT and you know it isn't reimbursable under Medicare. You also have a properly executed ABN on file. Which modifier(s) do you append to the code?

a) -AT.
b) -GA.
c) -GZ.

b) -GA

3. You have treated a patient for properly documented chronic care (hence, active) spinal CMT. Which modifier(s) do you append to the code and is it reimbursable?

a) -AT and yes.
b) -GA and yes.
c) -GY and no.

a) AT and yes

4. You are billing Medicare for therapy services, which you know are statutorily excluded for doctors of chiropractic. Which modifier(s) do you append to the code?

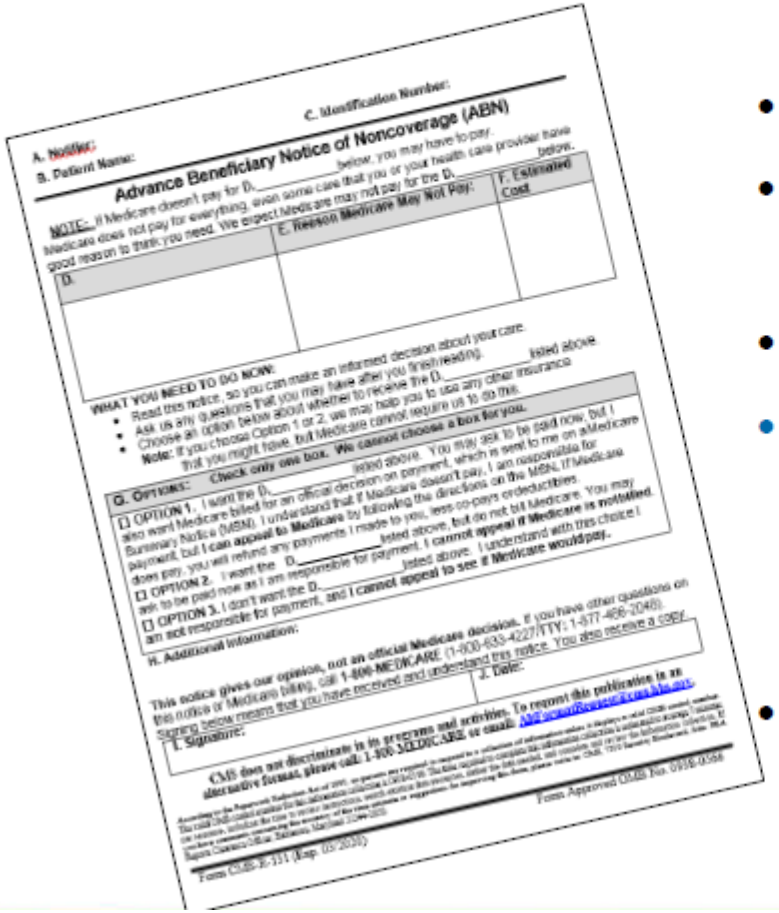
a) -GP
b) -GY
c) -GPGY

c) -GPGY

Maintenance Therapy

- Treatment considered maintenance when chiropractic treatment supportive, *not corrective*
  - When further clinical improvement cannot be expected from continuous ongoing care
- **Not a Medicare covered service, but must bill if option #1 is checked on ABN form by Pt.**
- Maintenance includes services that seek to:
  - Prevent disease
  - Promote health
  - Prolong/enhance quality of life
  - Maintain/prevent deterioration of chronic condition

Revised CMS ABN (CMS-R-131)



Advance Beneficiary Notice of Noncoverage (ABN)

- As of June 17, 2017
- Must have this form only
  - Dated 3/2020
- CMS form available
- http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html
- IOM 100-02, Chapter 15, Section 40

What is an ABN?

- Written notice that provider gives to Medicare beneficiary **prior** to service/procedure rendered
  - Believes Medicare will not pay some or all Medicare Fee for Services
  - If medical necessity denial, ABN indicates beneficiary is financially responsible
- Used for Maintenance Therapy visits

ABN Options

(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.**

- Beneficiary must make decision
- Provider **not** permitted to select

Extended Course of Treatment

- Single ABN (up to one year) acceptable:
  - ABN identifies all items/services and duration of period of treatment
  - No changes to treatment
  - Services are not added/deleted after treatment
- ANY changes require new ABN
- Each visit, patient's sign or initial back of ABN original and date
  - Not CMS requirement - Noridian advisement

ABN Not Required

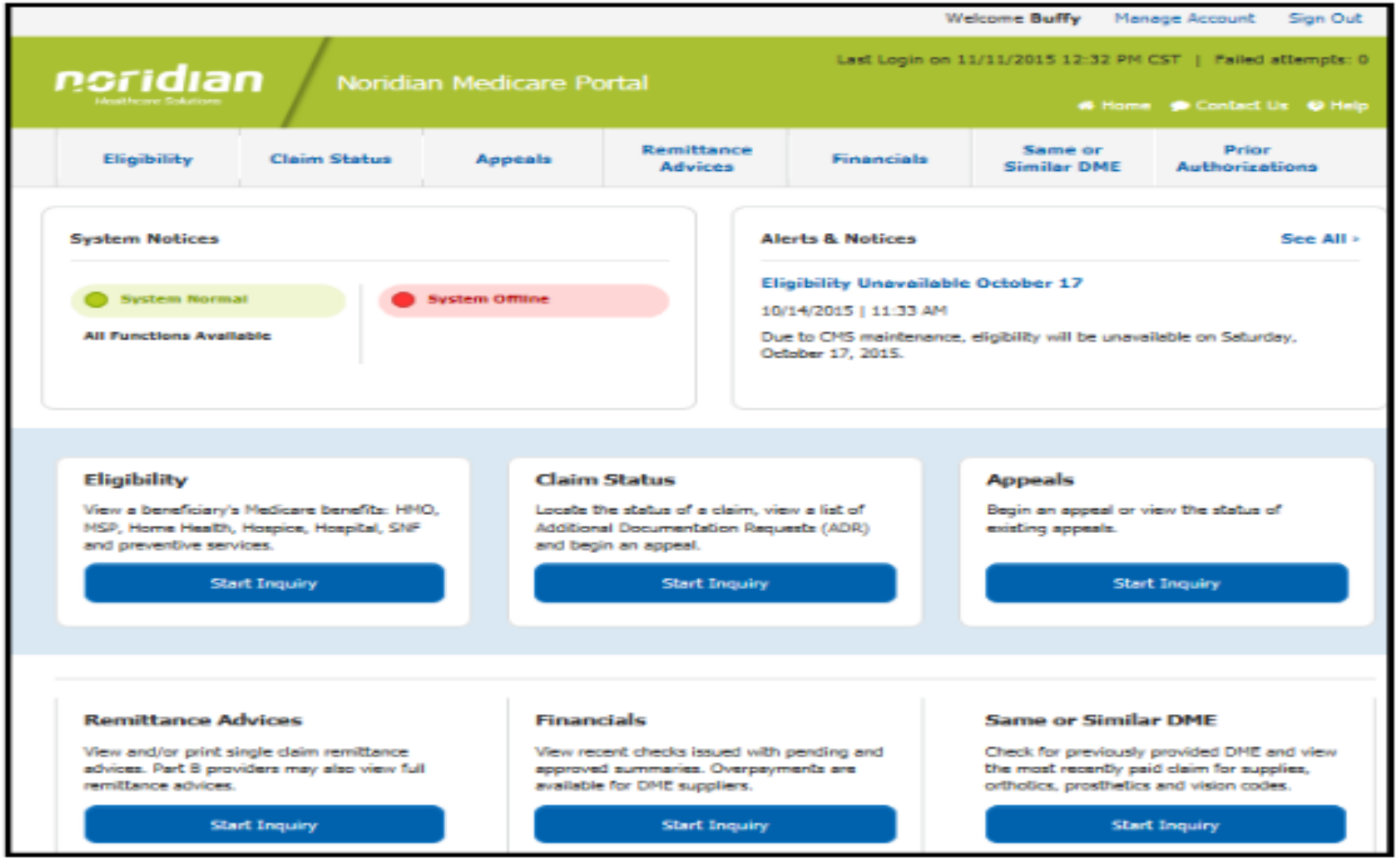
- ABN not required for services that are statutorily excluded – examples include:
  - Nutritional Supplements
  - Therapies
  - EKGs
  - Ultrasound
  - X-rays taken by Chiropractor
  - Office visits/E&M Codes
- Voluntary ABN non-covered items/services

ICD-10 Diagnoses List

Q. How can I obtain a list of covered ICD-10-CM diagnosis codes for a specific CPT or HCPCS code?

A. Navigate to the Noridian website to find the Chiropractic Local Coverage Determination (LCD) for California that includes ICD-10. Also, navigate to the CMS Medicare Coverage Database at https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-Official-ICD-10-PCS-Coding-Guidelines-.pdf

Noridian Medicare Portal Home Page



Questions?