

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:

Element	Percentage of Documentation Errors by Chiropractors
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.