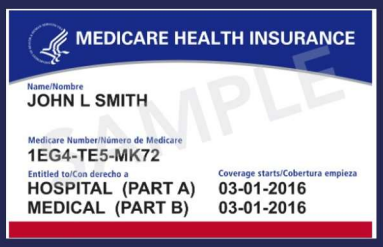
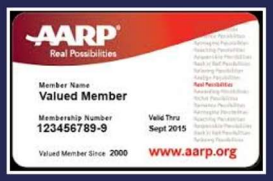


Medicare Billing Made Easy

Brandy Brimhall CPC, CMCO, CCCPC, CPCO, CPMA,
Certified Credentialing Specialist

Medicare Part B



Supplemental

Secondary

Let's Talk Enrollment - Medicare Part B

- NO Chiropractic opt-out
  - DCs must be enrolled as Par or Non-Par
  - No loopholes or special documents available to circumvent enrollment guidelines

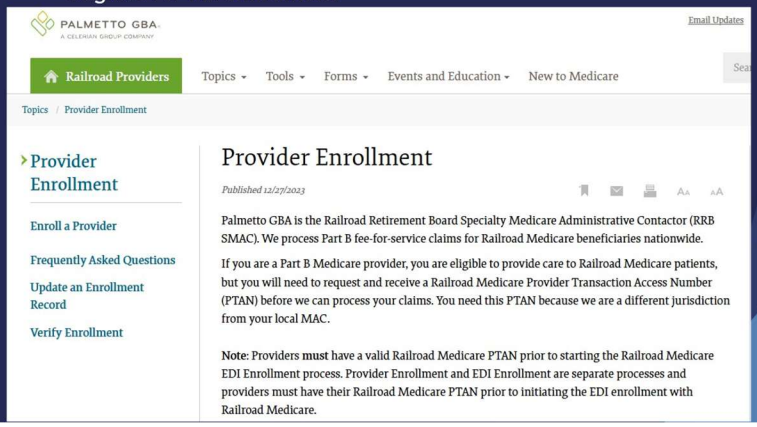
Misinformation #4: You can opt out of Medicare.

Correction: Doctors of Chiropractic (DC) may not opt out of Medicare. Note that opting out and being non-participating are not the same things. Chiropractors may decide to be participating or non-participating with regard to Medicare, but they may not opt out. (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.)

For further discussions of the Medicare "opt out" provision, see the "Medicare Benefit Policy Manual" (Chapter 15, Section 40; Definition of Physician/Practitioner) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf on the CMS website.

Enrolling with RR Medicare

- Not automatic with traditional Medicare
- Claims do not route to the same place
- Requires separate enrollment
  - Must be enrolled with traditional Medicare before eligible for RR enrollment



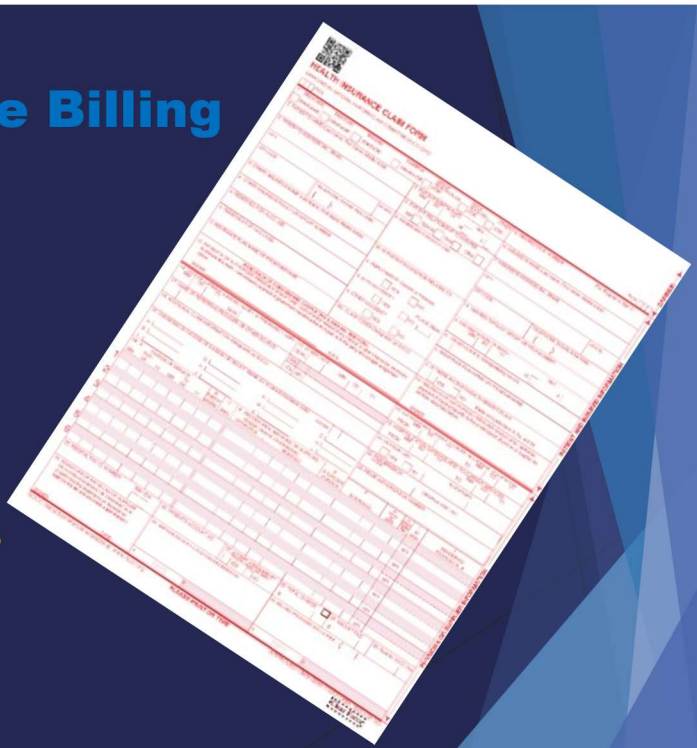
Enrolling with Medicare Part C

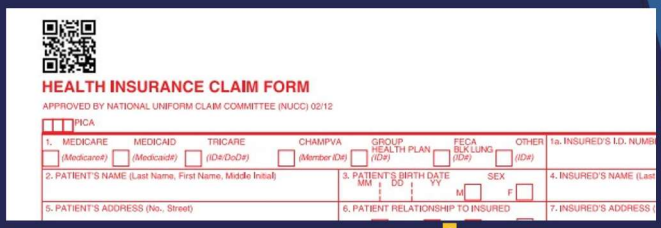
- Enrollment with commercial plans does not ensure enrollment with MedAdv plans/products
  - Providers are NOT required to enroll with MedAdv
- Adding these lines-of-business will require -
  - Medicare Part B enrollment first (PTAN)
  - Request for MedAdv products on initial commercial enrollment OR Separate enrollment to add these lines-of-business
  - If you have been enrolled under commercial products for a long time and have not updated existing enrollments, there is a chance you are not enrolled in all eligible plans (commercial and/or MedAdv)

Medicare Billing

Getting paid properly and efficiently

AND Being in the best position to keep what has been paid





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMB
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY	SEX M F			4. INSURED'S NAME (Last
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS

In submitting this claim for payment from federal funds, I certify that 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid law, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral (commonly known as Stark Law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under the direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal and NPI, license #, or SSN) of the primary individual rendering each services is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, though incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of on-physicians must be included on the physician's bills.

Medicare Par vs Non-Par

Participating (PAR)

- Must adhere to the Participating Provider fee schedule for covered services
- Must submit claims on behalf of Medicare beneficiaries
- Patients cannot self submit
- Obligated to follow-up and follow-thru with supplemental billing

Non-Participating

- May not collect more than the Limiting Charge fee schedule for covered services
- Patients CANNOT self submit
- May elect to "Accept" or "Not Accept" assignment
- This directs Medicare to reimburse the practice or the patient
- Not obligated to bill supplemental or secondary insurances to Medicare

Medicare Fees

- 98940

NON FAC PAR	NON FAC NON PAR	NON FAC LC
25.65	24.37	28.03

- 98941

NON FAC PAR	NON FAC NON PAR	NON FAC LC
37.28	35.42	40.73

- 98942

NON FAC PAR	NON FAC NON PAR	NON FAC LC
48.31	45.89	52.77

Preparing Clean and Compliant Medicare Claims

- No hyphens or punctuation
- Medicare Beneficiary Name as shown on card
- Billing facility fields and TIN (32,33 and 25) should be consistent with enrollment approval data

Item 14 - Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.

Item 24J - Enter the rendering provider's NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower unshaded portion.

This unprocessable instruction does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills as they do not require a rendering provider NPI.

NOTE: Effective May 23, 2008, the shaded portion of 24J is not to be reported.

Item 24E - This is a required field. Enter the diagnosis code reference number or letter (as appropriate, per form version) as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number/letter

Application of Coding

AT - Acute treatment (this modifier should be used when reporting service 98940, 98941, 98942)

GA - Waiver of liability statement issued as required by payer policy, individual case

GY - Item or service statutorily excluded, does not meet the definition of any medicare benefit or, for non-medicare insurers, is not a contract benefit

GP - Services delivered under an outpatient physical therapy plan of care

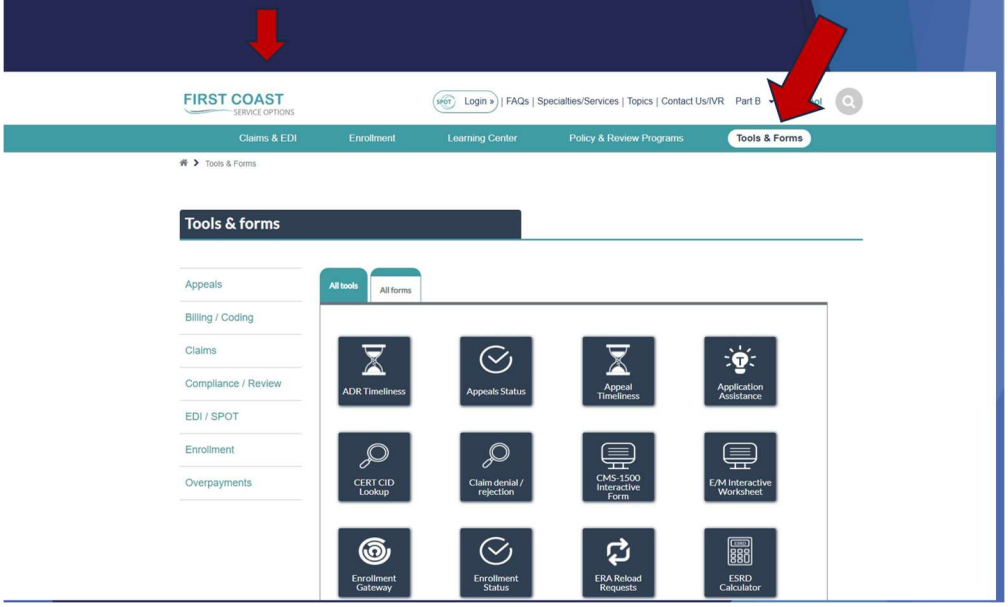
25 - Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

59 - Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or

At Your Fingertips

- www.medicare.fcso.com



Advanced Beneficiary Notice of Non-Coverage

- **Mandatory Use**
  - Must be issued to the patient prior to rendering covered, but not payable services
    - 98940-98942 Maintenance Care
- Do not use blanket ABN
  - Not every visit, Not every new year just in case, not all inclusive
- ABN is valid for the duration it is applicable
  - If new form is implemented by Medicare
  - If patient goes back to AT and then is released again to GA, a new ABN is needed

Clinic must complete upper portion, patient must complete lower portion

ABNs are Not Permitted for Use for MedAdv Plans

- As of May 5, 2014

Advance Beneficiary Notices (ABNs) are prohibited for use in Medicare Advantage Plans [1] [2] [3]. CMS specifically states that ABNs apply to patients enrolled in Medicare Fee-for-Service programs, and not for items or services provided under Medicare Advantage (MA) [1].

- To be valid, ABNs must be properly executed

Misinformation #5: You should get an Advance Beneficiary Notification (ABN) signed once for each patient and it will apply to all services, all visits.

Correction: The decision to deliver an ABN to a beneficiary 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. The ABN then allows the beneficiary to make an informed decision about receiving and paying for the service.

Getting 2027 Ready

- New deductible coming soon
- Updated fee schedule coming soon
- MedAdv policy changes
- New Medicare cards subject to be issued
- Patients subject to “replacing” traditional Medicare

Questions?

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