MEDICARE FOR CHIROPRACTORS 2023 UPDATES AND INTRODUCTION TO MEDICARE

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FORMS/VISUAL AID DISCLAIMER

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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)

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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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2021 EDITION

2021 BASED ON 2019 STATISTICS

Medicare Beneficiaries AT A GLANCE

WHO'S COVERED BY MEDICARE - 2019:

61.5M
Americans are enrolled in Medicare

3.8M
are new enrollees

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

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The Centers for Medicare & Medicaid Services (CMS) released the latest enrollment figures for Medicare on January 5th 2023.

As of September 2022, **65,103,807** people are enrolled in Medicare, an increase of 160,823 since the last report. **Enrollment in Medicare is up by 4 million enrollees since 2019, when total enrollment was around 61.5 million**.

2023, BASED ON 2022 STATISTICS

Of those:

- 34,984,295 are enrolled in Original Medicare.
- 30,119,512 are enrolled in Medicare Advantage or other health plans. This includes enrollment in Medicare Advantage plans with and without prescription drug coverage.
- 50,574,579 are enrolled in Medicare Part D. This includes enrollment in stand-alone prescription drug plans as well as Medicare Advantage plans that offer prescription drug coverage.
- Represents 19.8% of the US Population as of the 2020 Census (329.5 Million)

SOURCE: https://medicareadvocacy.org/medicare-enrollment-numbers/

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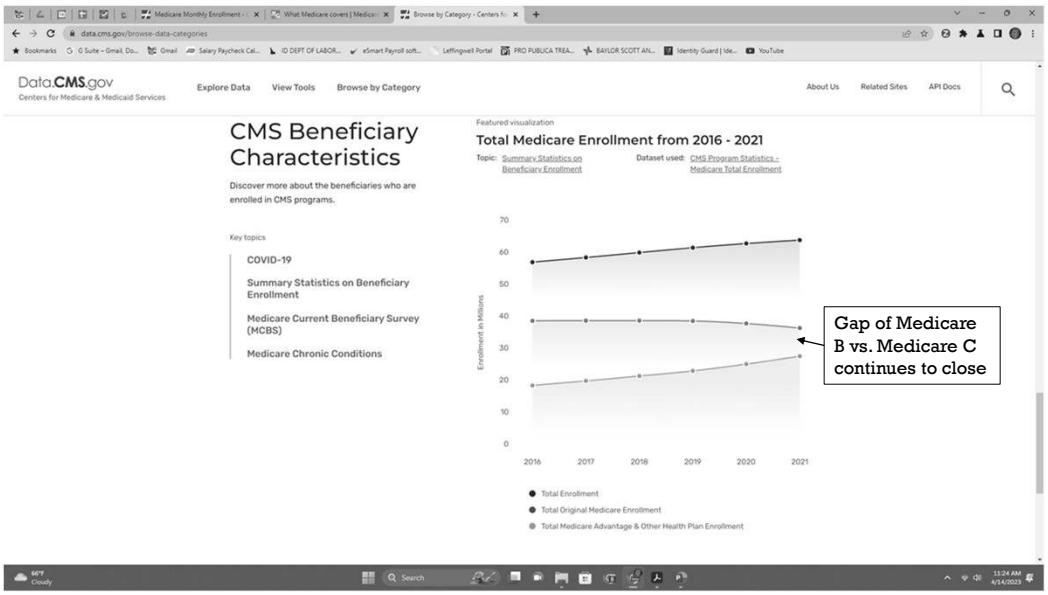

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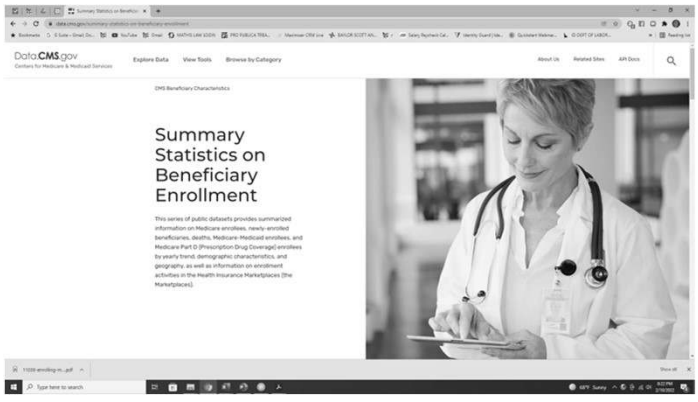
HOW MANY MEDICARE PATIENTS ARE IN MY STATE?



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

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•More than 1.6 million residents are enrolled in Medicare in Virginia; 12% percent are under age 65 and eligible due to a disability. 1.157 Mil in 2020

•About one third of Virginia Medicare beneficiaries are enrolled in Medicare Advantage plans (nationwide, it's about 46%). 37% in 2020

•All counties in Virginia have Medicare Advantage plans available, with plan availability ranging from 29 plans in Buckingham County to 66 plans in Henrico County.

•In Virginia, 42 insurers offer Medigap plans and more than 443,000 Medicare beneficiaries in the state have Medigap coverage.

•As of 2021, Virginia requires Medigap insurers to offer at least one plan to people under age 65 (but not including people with ESRD). Virtually all of the insurers are offering Plan A, and premiums are significantly higher for this population. But legislation is under consideration in 2023 that would limit premiums as of 2024 and extend Medigap protections to ESRD patients who are under 65.

•There are 24 stand-alone Part D prescription plans available in Virginia for 2022, with premiums ranging from about $5 to $108 per month. More than a million Virginia Medicare beneficiaries have Part D coverage, either under stand-alone plans or as part of their Medicare Advantage coverage.

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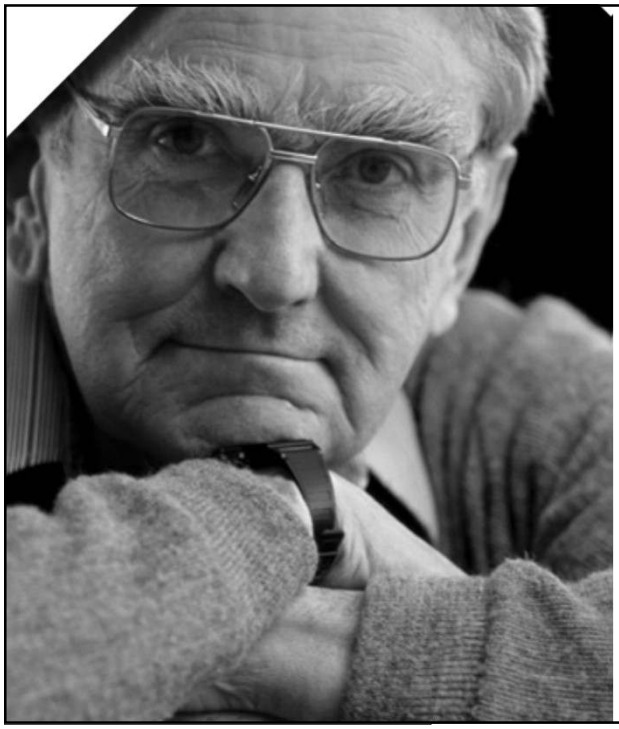

THE 'A-B-C-D' OF MEDICARE

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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

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MEDICARE PART A COSTS

Part A costs:	What you pay in 2023:
Premium	**$0 for most people** (because they paid Medicare taxes long enough while working - generally at least 10 years). This is sometimes called "premium-free Part A." Do I qualify? If you don't qualify for a premium-free Part A, you might be able to buy it. In 2023, the premium is either $278 or $506 each month, depending on how long you or your spouse worked and paid Medicare taxes. • You also have to sign up for Part B to buy Part A. • If you don't buy Part A when you're first eligible for Medicare (usually when you turn 65), you might pay a penalty. How much is the Part A penalty?
Deductible	**$1,600** for each time you're admitted to the hospital per benefit period before Original Medicare starts to pay. There's no limit to the number of benefit periods you can have.
Inpatient stays (copayments)	Days 1-60: $0 after you pay your Part A deductible Days 61-90: $400 each day Days 91-150: $800 each day while using your 60 lifetime reserve days After day 150: You pay all costs

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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

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MEDICARE PART B COSTS

Part B costs:	What you pay 2023:
Premium	**$164.90 each month** (or higher depending on your income). The amount can change each year. You'll pay the premium each month, even if you don't get any Part B-covered services. Who pays a higher premium because of income? ⓘ How do I pay my Part B premiums? ⓘ You might pay a penalty if you don't sign up for Part B when you're first eligible for Medicare (usually when you turn 65). Check when I should sign up for Part B. **How much is the Part B late enrollment penalty?** • You'll pay an extra 10% for each year you could have signed up for Part B, but didn't. • This penalty is added to your monthly Part B premium. (You may also pay a higher premium depending on your income.) • It's not a one-time late fee – you'll pay the penalty for as long as you have Part B. • Generally, you **won't** have to pay a penalty if you qualify for a Special Enrollment Period. To qualify, you (or your spouse) must still be working and you must have health coverage based on that job. Examples of the Part B penalty. ⓘ
Deductible	**You'll pay $226, before Original Medicare starts to pay.** You pay this deductible once each year.
Costs for services (coinsurance)	You'll usually pay 20% of the cost for each Medicare-covered service or item after you've paid your deductible.

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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?

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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

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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

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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.

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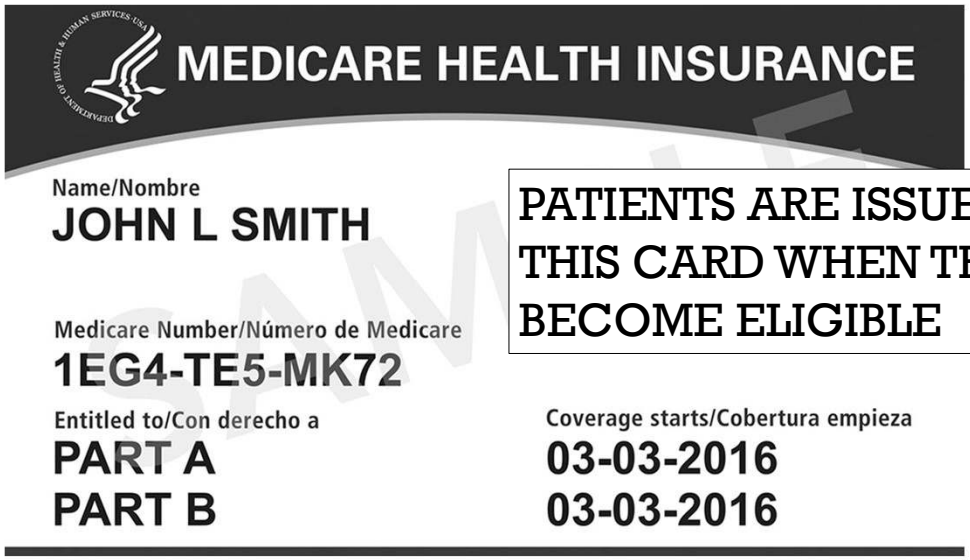

PATIENTS ARE ISSUED THIS CARD WHEN THEY BECOME ELIGIBLE

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This is a Medicare Supplemental Plan, aka Medigap

It is Supplemental to Medicare Part B

Plan "Letter" Determines Level of Payment

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PLAN F

	Medigap plans									
Benefits	**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

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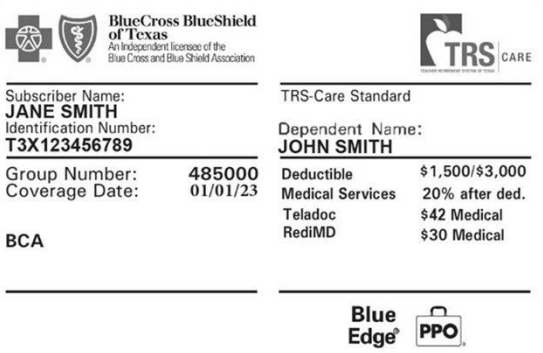
"TRUE" SECONDARY PLAN

- 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 would be necessary



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IDENTIFYING MEDICARE ADVANTAGE PLANS

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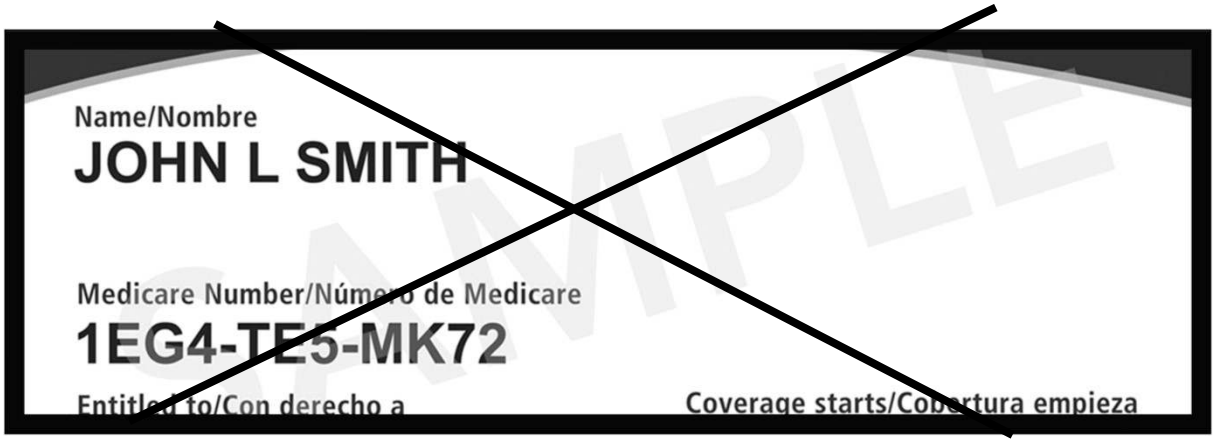

IF A PATIENT HAS A MEDICARE ADVANTAGE PLAN, DO NOT ENTER THIS CARD IN THE BILLING SYSTEM- JUST KEEP A COPY ON FILE

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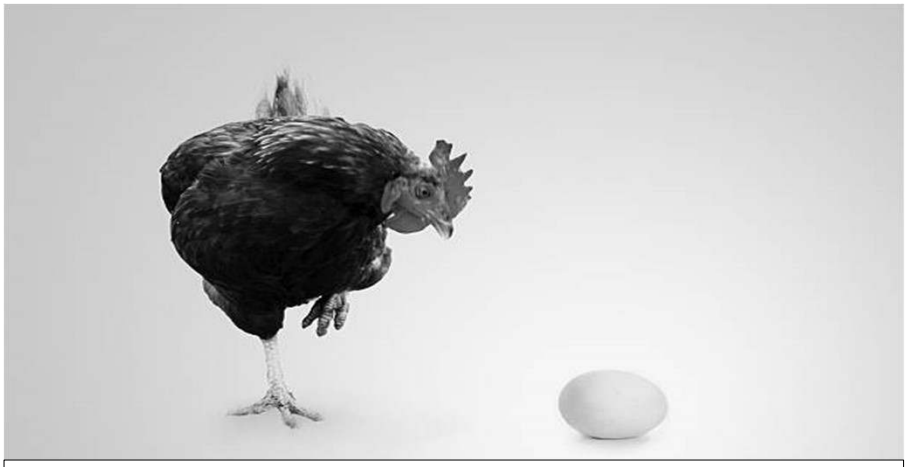
MEDICARE AS A SECONDARY PAYER



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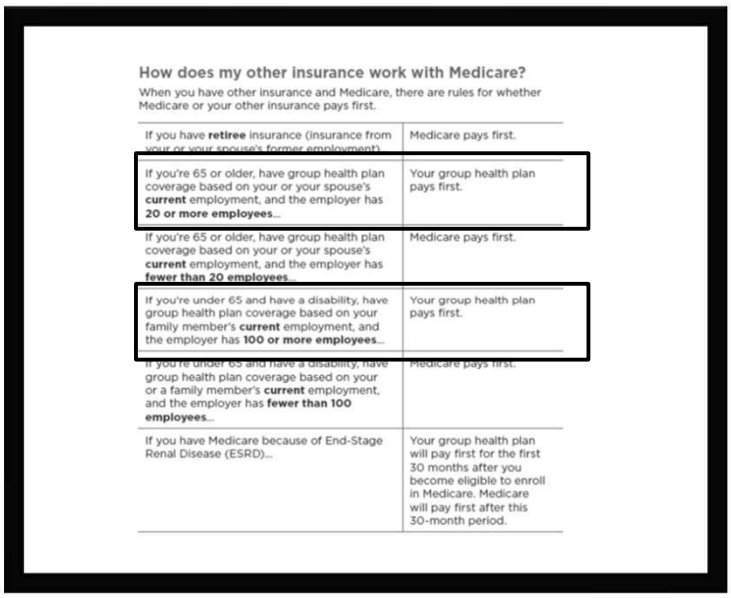

How does my other insurance work with Medicare?

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

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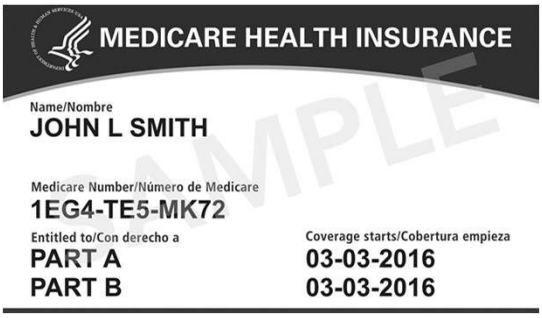
WHEN A PATIENT BRINGS YOU THIS…



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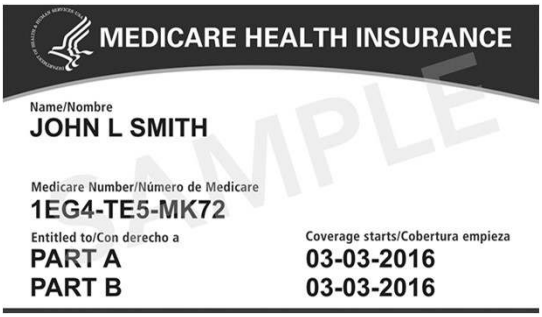
WHEN A PATIENT BRINGS YOU THIS…



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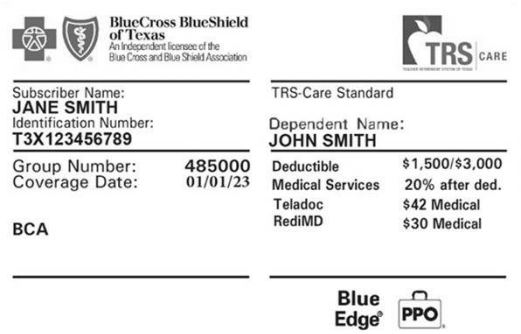
Check Benefits, may be a true secondary



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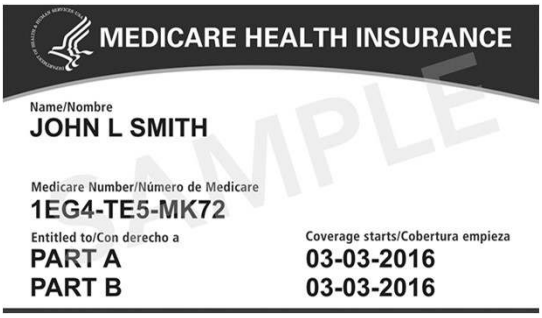
WHEN A PATIENT BRINGS YOU THIS…



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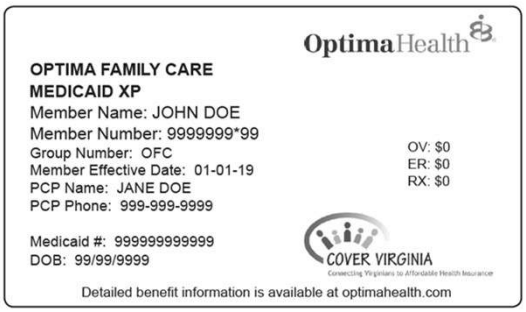
Dual Eligible Patient



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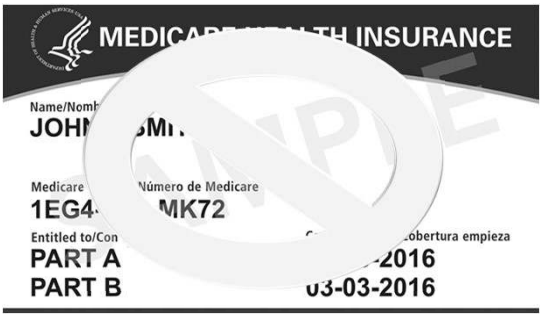
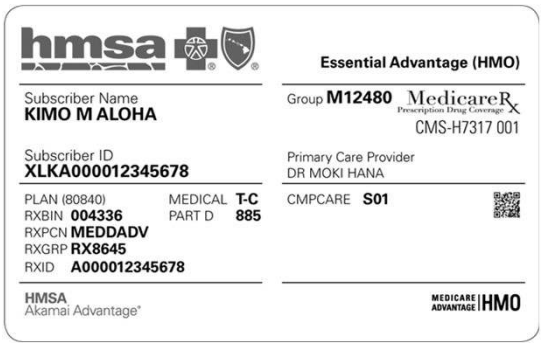
WHEN A PATIENT BRINGS YOU THIS…

Medicare Advantage REPLACES Medicare B





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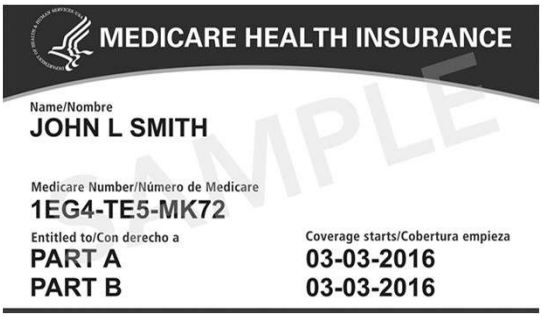
WHEN A PATIENT BRINGS YOU THIS… STILL WORKING, 60 EMPLOYEES



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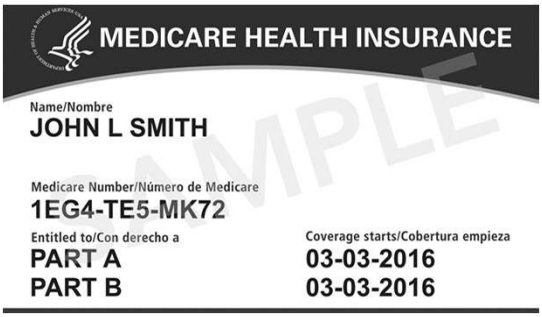
WHEN A PATIENT BRINGS YOU THIS… AUTO ACCIDENT



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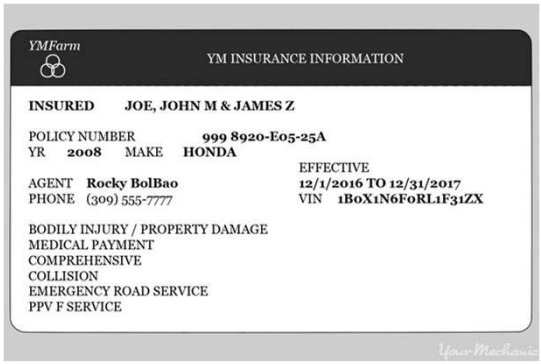

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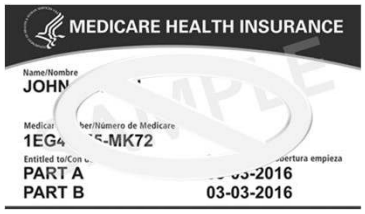
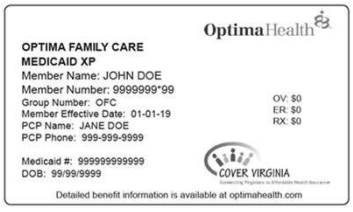
WHEN A PATIENT BRINGS YOU THIS…

Dual Eligible MA Patient





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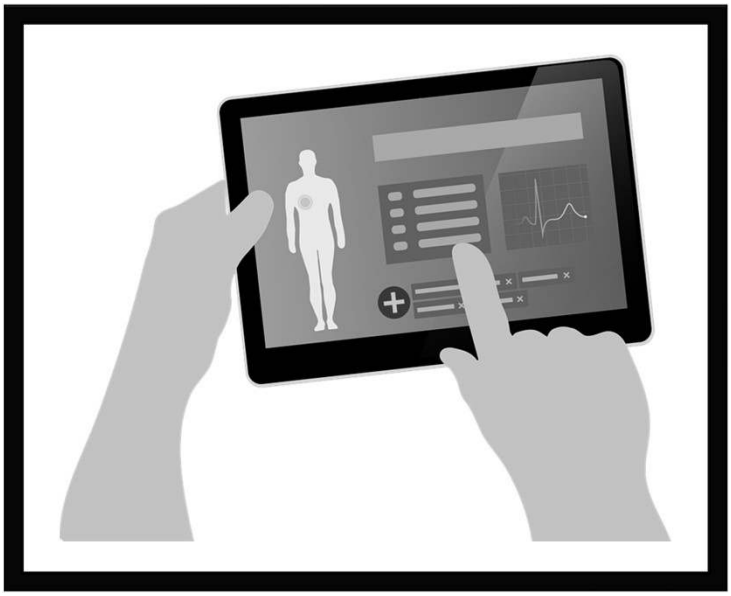

CHIROPRACTIC COVERAGE AND CLINICAL DOCUMENTATION REQUIREMENTS

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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)

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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.

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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.

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An x-ray may be used to document subluxation. The x-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific x-ray evidence is warranted, an x-ray is considered reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted provided the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent. A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.

ESTABLISH MEDICAL NECESSITY

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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.

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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.

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HOW MANY VISITS....

240.1.5 - Treatment Parameters
(Rev. 23, Issued: 10-08-04, Effective: 10-01-04, Implementation: 10-04-04)
B3-2251.5

The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxation (e.g., strains or sprains) problems may require as many as three months of treatment but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.

Chronic spinal joint condition implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already "set" and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

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Misinformation #1: There is a 12 visit cap or limit for chiropractic services.

Correction: There are no caps/limits in Medicare for covered chiropractic care rendered by chiropractors who meet Medicare's licensure and other requirements as specified in the "Medicare Benefit Policy Manual," Chapter 15, Section 30.5 (this manual is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html on the CMS website). Your Medicare Administrative Contractor (MAC) may have review screens (numbers of visits at which the MAC might require a review of documentation before allowing further care), but caps/limits are not allowed.

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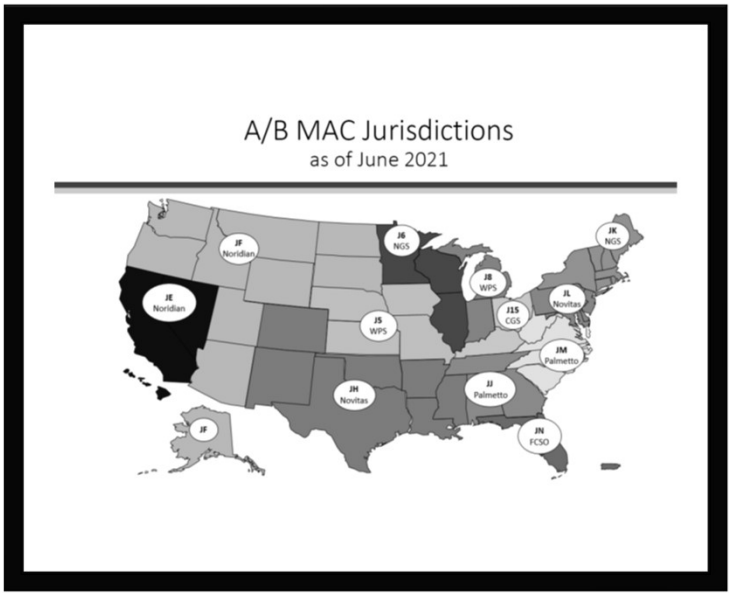

WHO IS MY MEDICARE PART B ADMINISTRATIVE CONTRACTOR (MAC)?

- 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)

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LCD'S AND LCA'S

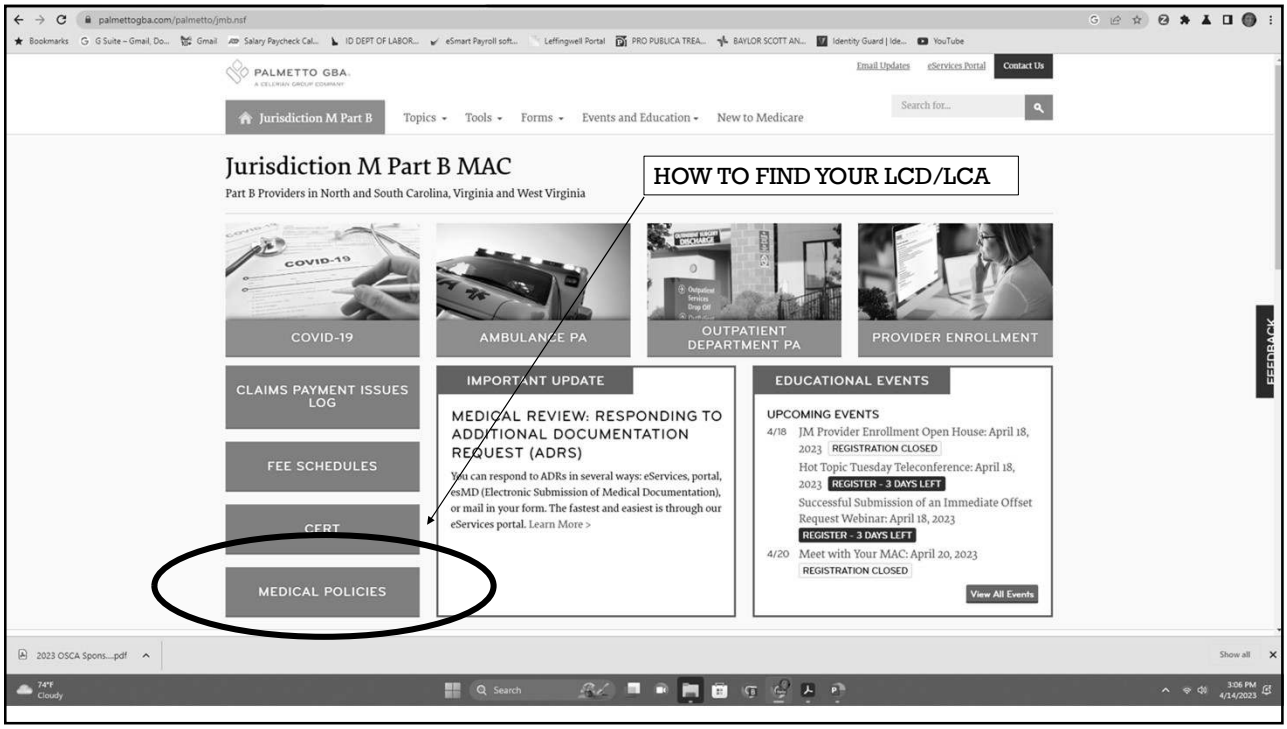
- **LCD= LOCAL COVERAGE DETERMINATION**
  - Provides information on how to establish medical necessity, limitations and documentation requirements for initial and subsequent visits (Palmetto LCD is document L37387)
- **LCA= LOCAL COVERAGE ARTICLE**
  - Provides Billing and Coding Guidance (Palmetto LCA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

45

- **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

46


HOW TO FIND YOUR LCD/LCA
PALMETTO GBA
Jurisdiction M Part B
Topics
Tools
Forms
Events and Education
New to Medicare
Jurisdiction M Part B MAC
Part B Providers in North and South Carolina, Virginia and West Virginia
COVID-19
AMBULANCE PA
OUTPATIENT DEPARTMENT PA
PROVIDER ENROLLMENT
CLAIMS PAYMENT ISSUES LOG
FEE SCHEDULES
CERT
MEDICAL POLICIES
IMPORTANT UPDATE
MEDICAL REVIEW: RESPONDING TO ADDITIONAL DOCUMENTATION REQUEST (ADRS)
EDUCATIONAL EVENTS
UPCOMING EVENTS
View All Events

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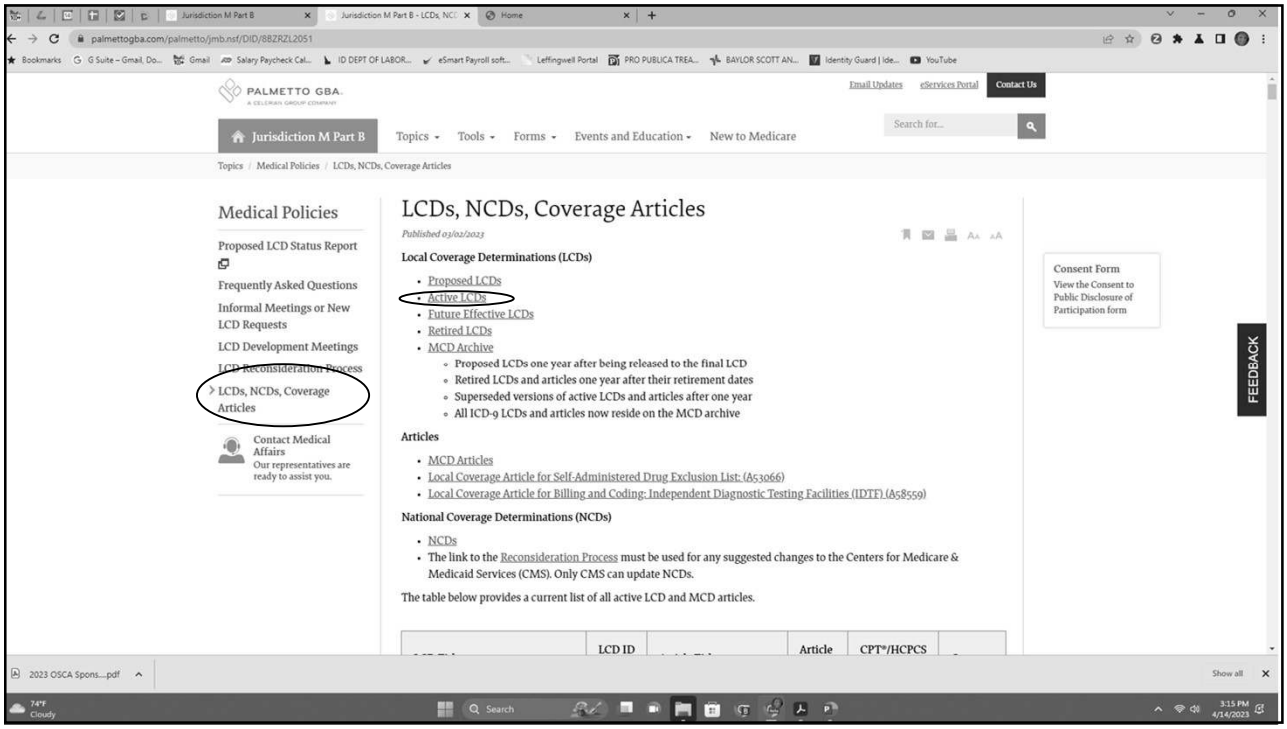
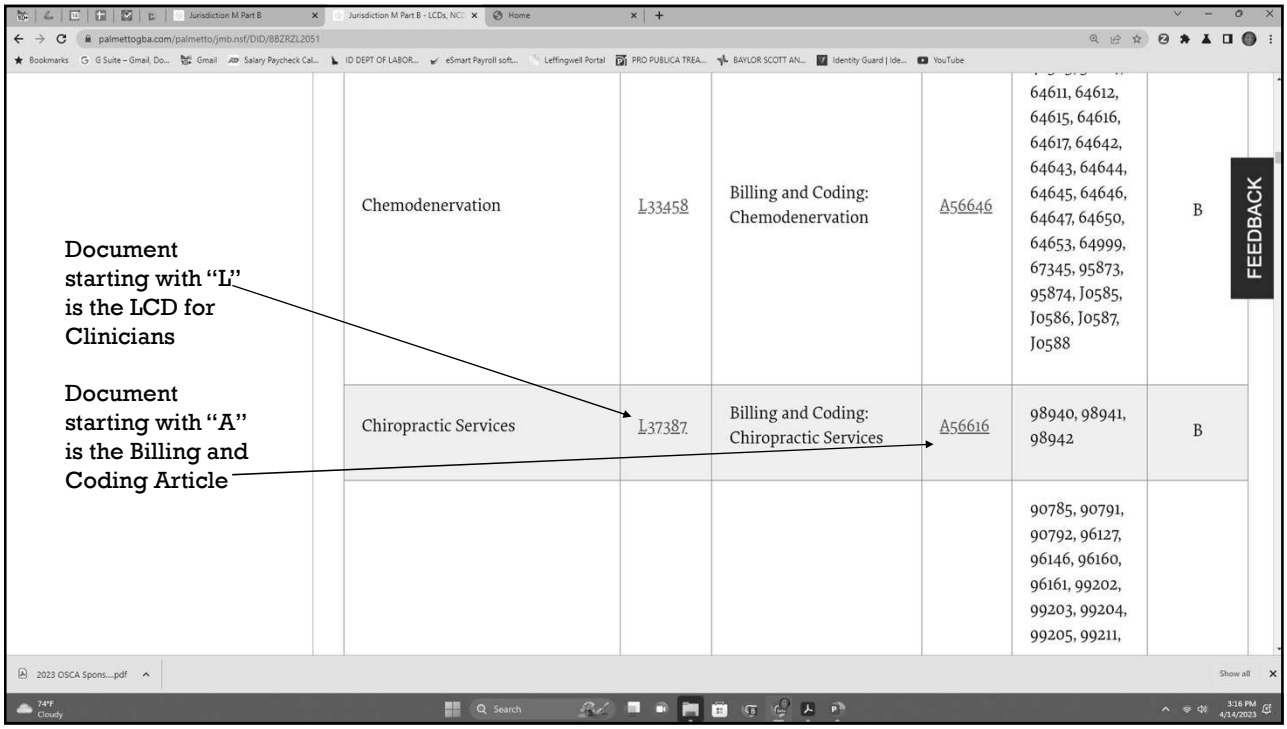

Medical Policies
Proposed LCD Status Report
Frequently Asked Questions
Informal Meetings or New LCD Requests
LCD Development Meetings
LCD Reconsideration Process
LCDs, NCDs, Coverage Articles
Contact Medical Affairs
Our representatives are ready to assist you.
LCDs, NCDs, Coverage Articles
Published 03/02/2023
Local Coverage Determinations (LCDs)
Proposed LCDs
Active LCDs
Future Effective LCDs
Retired LCDs
MCD Archive
Proposed LCDs one year after being released to the final LCD
Retired LCDs and articles one year after their retirement dates
Superseded versions of active LCDs and articles after one year
All ICD-9 LCDs and articles now reside on the MCD archive
Articles
MCD Articles
Local Coverage Article for Self-Administered Drug Exclusion List: (A53066)
Local Coverage Article for Billing and Coding: Independent Diagnostic Testing Facilities (IDTF) (A58559)
National Coverage Determinations (NCDs)
NCDs
The link to the Reconsideration Process must be used for any suggested changes to the Centers for Medicare & Medicaid Services (CMS). Only CMS can update NCDs.
The table below provides a current list of all active LCD and MCD articles.
Consent Form
View the Consent to Public Disclosure of Participation form
FEEDBACK

48


Document starting with "L" is the LCD for Clinicians
Document starting with "A" is the Billing and Coding Article
Chemodenervation
L33458
Billing and Coding: Chemodenervation
A56646
64611, 64612, 64615, 64616, 64617, 64642, 64643, 64644, 64645, 64646, 64647, 64650, 64653, 64999, 67345, 95873, 95874, J0585, J0586, J0587, J0588
B
Chiropractic Services
L37387
Billing and Coding: Chiropractic Services
A56616
98940, 98941, 98942
B
90785, 90791, 90792, 96127, 96146, 96160, 96161, 99202, 99203, 99204, 99205, 99211,
FEEDBACK

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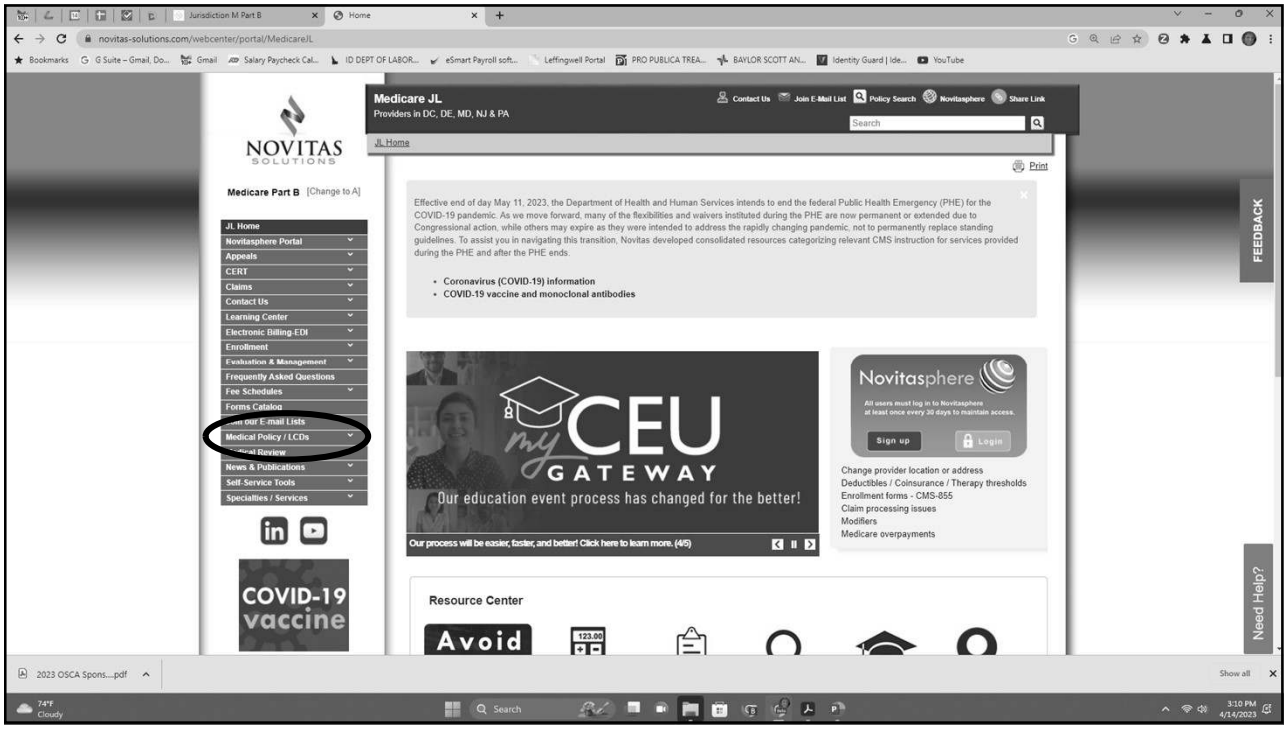
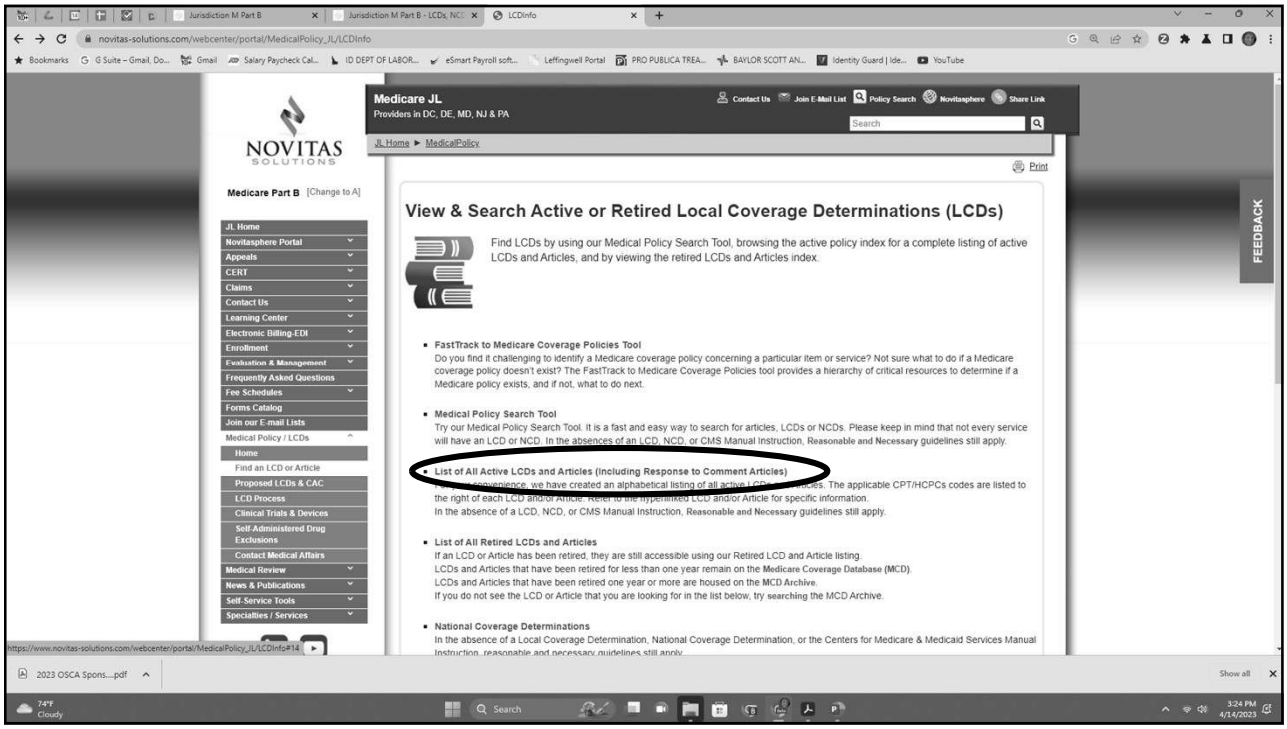

Medicare JL
Providers in DC, DE, MD, NJ & PA
NOVITAS SOLUTIONS
Medicare Part B [Change to A]
JL Home
Novitasphere Portal
Appeals
CERT
Claims
Contact Us
Learning Center
Electronic Billing-EDI
Enrollment
Evaluation & Management
Frequently Asked Questions
Fee Schedules
Forms Catalog
Medical Policy / LCDs
News & Publications
Self-Service Tools
Specialties / Services
COVID-19 vaccine
Effective end of day May 11, 2023, the Department of Health and Human Services intends to end the federal Public Health Emergency (PHE) for the COVID-19 pandemic. As we move forward, many of the flexibilities and waivers instituted during the PHE are now permanent or extended due to Congressional action, while others may expire as they were intended to address the rapidly changing pandemic, not to permanently replace standing guidelines. To assist you in navigating this transition, Novitas developed consolidated resources categorizing relevant CMS instruction for services provided during the PHE and after the PHE ends.
Coronavirus (COVID-19) information
COVID-19 vaccine and monoclonal antibodies
myCEU GATEWAY
Our education event process has changed for the better!
Our process will be easier, faster, and better! Click here to learn more. (4/5)
Novitasphere
Sign up
Login
Change provider location or address
Deductibles / Coinsurance / Therapy thresholds
Enrollment forms - CMS-855
Claim processing issues
Modifiers
Medicare overpayments
Resource Center
Avoid
FEEDBACK
Need Help?

50


Medicare JL
Providers in DC, DE, MD, NJ & PA
NOVITAS SOLUTIONS
Medicare Part B [Change to A]
JL Home
Novitasphere Portal
Appeals
CERT
Claims
Contact Us
Learning Center
Electronic Billing-EDI
Enrollment
Evaluation & Management
Frequently Asked Questions
Fee Schedules
Forms Catalog
Join our E-mail Lists
Medical Policy / LCDs
Home
Find an LCD or Article
Proposed LCDs & CAC
LCD Process
Clinical Trials & Devices
Self-Administered Drug Exclusions
Contact Medical Affairs
Medical Review
News & Publications
Self-Service Tools
Specialties / Services
JL Home ▶ MedicalPolicy
Print
View & Search Active or Retired Local Coverage Determinations (LCDs)
Find LCDs by using our Medical Policy Search Tool, browsing the active policy index for a complete listing of active LCDs and Articles, and by viewing the retired LCDs and Articles index.
FastTrack to Medicare Coverage Policies Tool
Do you find it challenging to identify a Medicare coverage policy concerning a particular item or service? Not sure what to do if a Medicare coverage policy doesn't exist? The FastTrack to Medicare Coverage Policies tool provides a hierarchy of critical resources to determine if a Medicare policy exists, and if not, what to do next.
Medical Policy Search Tool
Try our Medical Policy Search Tool. It is a fast and easy way to search for articles, LCDs or NCDs. Please keep in mind that not every service will have an LCD or NCD. In the absences of an LCD, NCD, or CMS Manual Instruction, Reasonable and Necessary guidelines still apply.
List of All Active LCDs and Articles (Including Response to Comment Articles)
For your convenience, we have created an alphabetical listing of all active LCDs and Articles. The applicable CPT/HCPCs codes are listed to the right of each LCD and/or Article. Refer to the hyperlinked LCD and/or Article for specific information.
In the absence of a LCD, NCD, or CMS Manual Instruction, Reasonable and Necessary guidelines still apply.
List of All Retired LCDs and Articles
If an LCD or Article has been retired, they are still accessible using our Retired LCD and Article listing.
LCDs and Articles that have been retired for less than one year remain on the Medicare Coverage Database (MCD).
LCDs and Articles that have been retired one year or more are housed on the MCD Archive.
If you do not see the LCD or Article that you are looking for in the list below, try searching the MCD Archive.
National Coverage Determinations
In the absence of a Local Coverage Determination, National Coverage Determination, or the Centers for Medicare & Medicaid Services Manual
FEEDBACK

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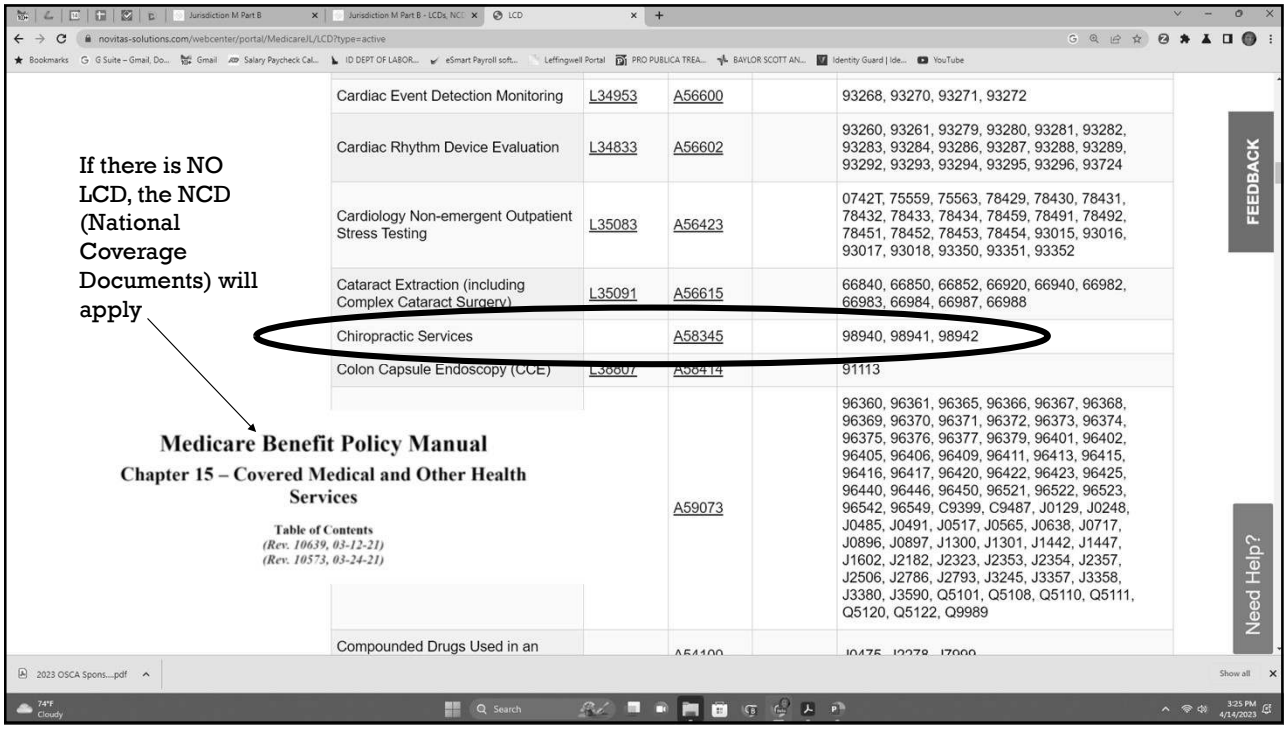
If there is NO LCD, the NCD (National Coverage Documents) will apply
Medicare Benefit Policy Manual
Chapter 15 – Covered Medical and Other Health Services
Table of Contents
(Rev. 10639, 03-12-21)
(Rev. 10573, 03-24-21)
Cardiac Event Detection Monitoring L34953 A56600 93268, 93270, 93271, 93272
Cardiac Rhythm Device Evaluation L34833 A56602 93260, 93261, 93279, 93280, 93281, 93282, 93283, 93284, 93286, 93287, 93288, 93289, 93292, 93293, 93294, 93295, 93296, 93724
Cardiology Non-emergent Outpatient Stress Testing L35083 A56423 0742T, 75559, 75563, 78429, 78430, 78431, 78432, 78433, 78434, 78459, 78491, 78492, 78451, 78452, 78453, 78454, 93015, 93016, 93017, 93018, 93350, 93351, 93352
Cataract Extraction (including Complex Cataract Surgery) L35091 A56615 66840, 66850, 66852, 66920, 66940, 66982, 66983, 66984, 66987, 66988
Chiropractic Services A58345 98940, 98941, 98942
Colon Capsule Endoscopy (CCE) L36607 A58414 91113
A59073 96360, 96361, 96365, 96366, 96367, 96368, 96369, 96370, 96371, 96372, 96373, 96374, 96375, 96376, 96377, 96379, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96446, 96450, 96521, 96522, 96523, 96542, 96549, C9399, C9487, J0129, J0248, J0485, J0491, J0517, J0565, J0638, J0717, J0896, J0897, J1300, J1301, J1442, J1447, J1602, J2182, J2323, J2353, J2354, J2357, J2506, J2786, J2793, J3245, J3357, J3358, J3380, J3590, Q5101, Q5108, Q5110, Q5111, Q5120, Q5122, Q9989
Compounded Drugs Used in an
FEEDBACK
Need Help?

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ADDITIONAL AIDS FOR DOCUMENTATION COMPLIANCE

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2021-03
Date
2021-03
Topic Provider Compliance
Title Medicare Documentation Job Aid For Doctors of Chiropractic
Format
Educational Tool

ICN: MLN1232664

Publication Description: A new Medicare Documentation Job Aid For Doctors of Chiropractic Medicare Learning Network Fact Sheet is available. Learn about how to respond to medical records requests, documentation to support medical necessity and medical records which support “corrective treatment.”

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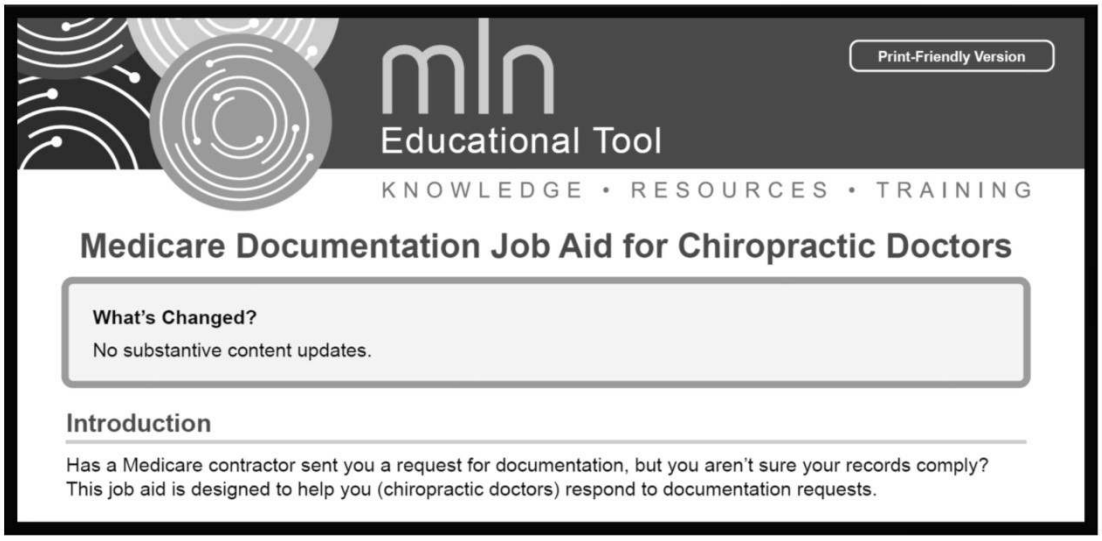
mln
Educational Tool
KNOWLEDGE • RESOURCES • TRAINING
Print-Friendly Version
Medicare Documentation Job Aid for Chiropractic Doctors
What's Changed?
No substantive content updates.
Introduction
Has a Medicare contractor sent you a request for documentation, but you aren't sure your records comply? This job aid is designed to help you (chiropractic doctors) respond to documentation requests.

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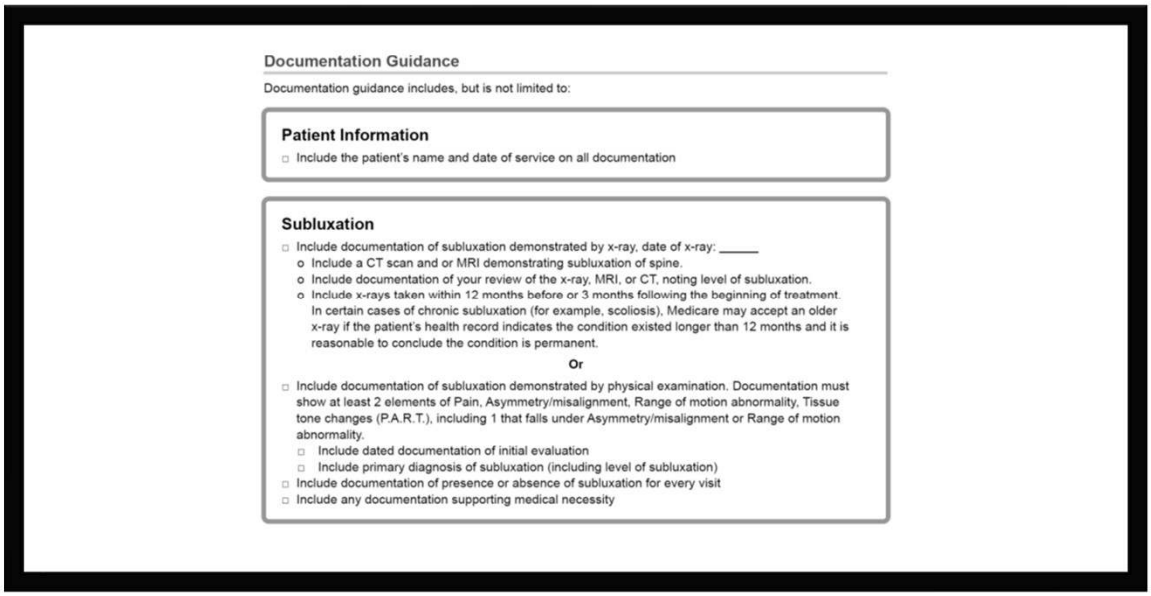
Documentation Guidance
Documentation guidance includes, but is not limited to:
Patient Information
□ Include the patient's name and date of service on all documentation
Subluxation
□ Include documentation of subluxation demonstrated by x-ray, date of x-ray: _____
o Include a CT scan and or MRI demonstrating subluxation of spine.
o Include documentation of your review of the x-ray, MRI, or CT, noting level of subluxation.
o Include x-rays taken within 12 months before or 3 months following the beginning of treatment. In certain cases of chronic subluxation (for example, scoliosis), Medicare may accept an older x-ray if the patient's health record indicates the condition existed longer than 12 months and it is reasonable to conclude the condition is permanent.
Or
□ Include documentation of subluxation demonstrated by physical examination. Documentation must show at least 2 elements of Pain, Asymmetry/misalignment, Range of motion abnormality, Tissue tone changes (P.A.R.T.), including 1 that falls under Asymmetry/misalignment or Range of motion abnormality.
□ Include dated documentation of initial evaluation
□ Include primary diagnosis of subluxation (including level of subluxation)
□ Include documentation of presence or absence of subluxation for every visit
□ Include any documentation supporting medical necessity

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Initial Evaluation

- History
  - Date of initial treatment
  - Description of current illness
  - Symptoms directly related to level of subluxation causing patient to seek treatment
  - Family history, if relevant (recommended)
  - Past health history (recommended)
  - Mechanism of trauma (recommended)
  - Quality and character of symptoms or problem (recommended)
  - Onset, duration, intensity, frequency, location, and radiation of symptoms (recommended)
  - Aggravating or relieving factors (recommended)
  - Prior interventions, treatments, medication, and secondary complaints (recommended)
- Contraindications (for example, risk of injury to patient from dynamic thrust or discussion of risk with patient) (recommended)
- Physical examination (P.A.R.T.)
  - Evaluation of musculoskeletal and nervous system through physical examination
- Documentation of presence or absence of subluxation for every visit
- Treatment given on day of visit (if applicable)
  - Include specific areas and levels of the spine where manipulation was performed.
  - Medicare may cover treatment performed using hand-held devices; however, Medicare does not offer additional payment or recognize an extra charge for use of the device.

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Treatment Plan

- Frequency and duration of visits (recommended)
- Specific treatment goals (recommended)
- Objective measures to evaluate treatment effectiveness (recommended)

Subsequent Visit

- History
  - Review of chief complaint
  - Changes since last visit
  - System review, if relevant
- Physical examination (P.A.R.T.)
  - Assessment of change in patient condition since last visit
  - Evaluation of treatment effectiveness
- Documentation of presence or absence of subluxation for every visit
- Treatment given on day of visit (include specific areas and levels of spine where manipulation was performed)

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General Guidelines

- Make sure medical records submitted show that the service is a corrective treatment, rather than maintenance
  - For Medicare purposes, place an AT modifier on a claim when you provide active or corrective treatment to treat acute or chronic subluxation
    - Do not use Modifier AT when you perform maintenance therapy
    - Only use modifier AT when chiropractic manipulation is reasonable and necessary as defined by national and local policy
    - **Note:** Presence of the AT modifier may not indicate the service is reasonable and necessary. As always, contractors may deny after medical review.

    Make sure you know these policies, along with any local coverage determination in your area, to better understand how active or corrective chiropractic services are covered.
- Submit records for all dates of service on a claim
- Make sure documentation is legible and complete, including signatures
- Include legible signatures and credentials of professionals providing services
  - If signatures are missing or illegible, include a completed signature attestation statement.
  - For illegible signatures, include a signature log.
  - For electronic health records, include a copy of electronic signature policy and procedures describing how notes and orders are signed and dated. Validating electronic signatures depends on obtaining this information.
- Include abbreviation key (if applicable)
- Include any other documentation to support medical necessity of services billed, as well as documentation specifically requested in an additional documentation request (ADR) letter
- Include a copy of the Advance Beneficiary Notice of Noncoverage (if applicable)

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CPT CODES THAT ARE COVERED

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

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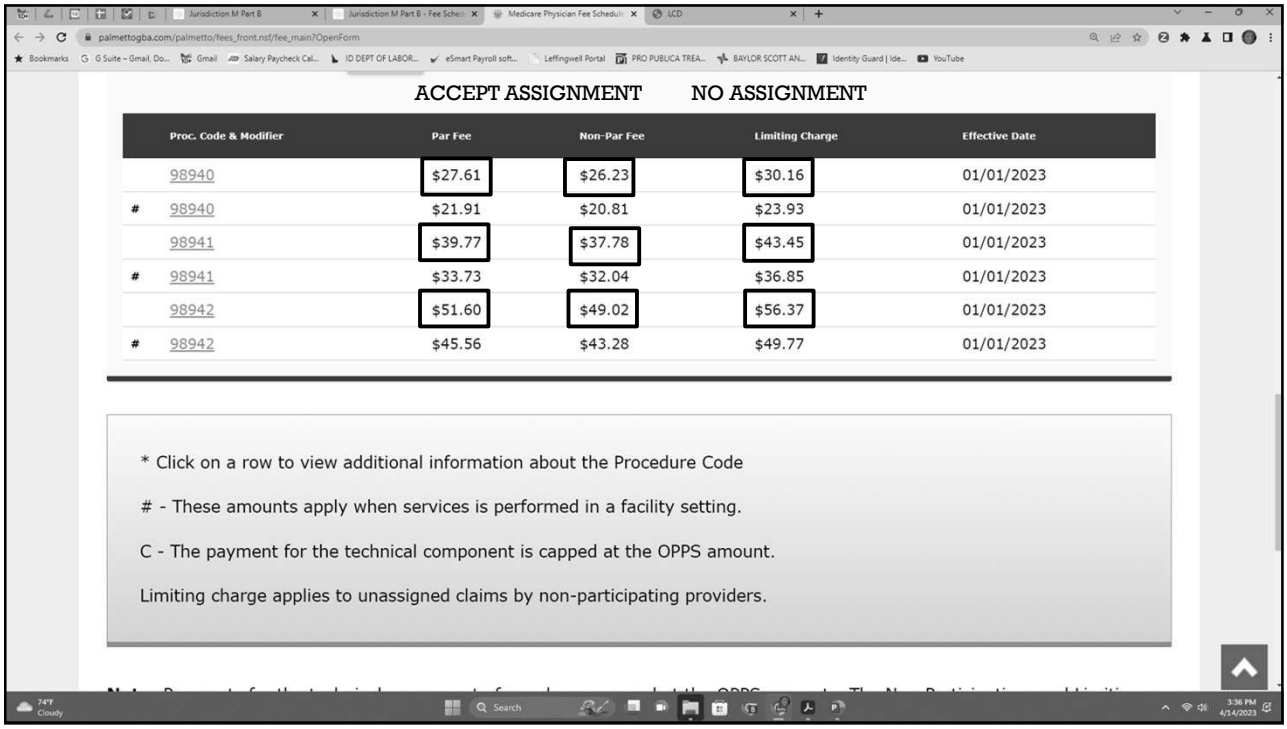

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ABOUT THE NON-PAR LIMITING CHARGE

- **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/

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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 ONLY CODES PERMITTED IN BOX 21A OF THE CMS 1500 CLAIM FORM

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

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-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

65

EXCERPTS FROM PALMETTO GBA LCA

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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

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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

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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)

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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

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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

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BILLING MEDICARE FOR STATUTORILY NON-COVERED SERVICES

- You are not required to bill for non covered services (ie: exams, xrays, therapy) **BUT**
- Patients may want you to file the claim
- Patient may have a true secondary
- Medicare may be a secondary payer

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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

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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**

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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

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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.**

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MEDICARE B AND MEDICARE ADVANTAGE TIMELY FILING

1 YEAR
FROM DATE OF SERVICE

77

14 BUSINESS DAYS FROM THE DATE IT IS ACCEPTED FOR ADJUDICATION

MEDICARE PROCESSING TIME

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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

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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**

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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.

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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.

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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.

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THE MEDICARE ABN AND CHIROPRACTIC

- ONLY MEDICARE PART B
- ONLY FOR SPINAL MANIPULATIONS
- OTHER SERVICES UNDER A VOLUNTARY ABN
- USE THE MOST CURRENT FORM Form CMS-R-131 (Exp.01/31/2026)
- 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)

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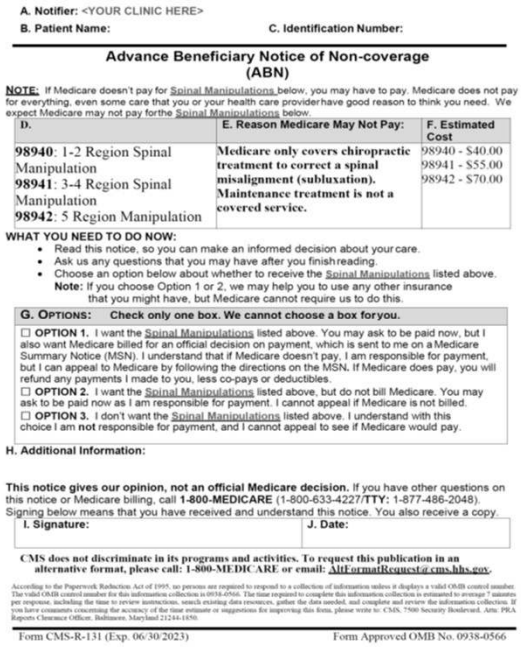


A. **Notifier:** <YOUR CLINIC HERE>

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.

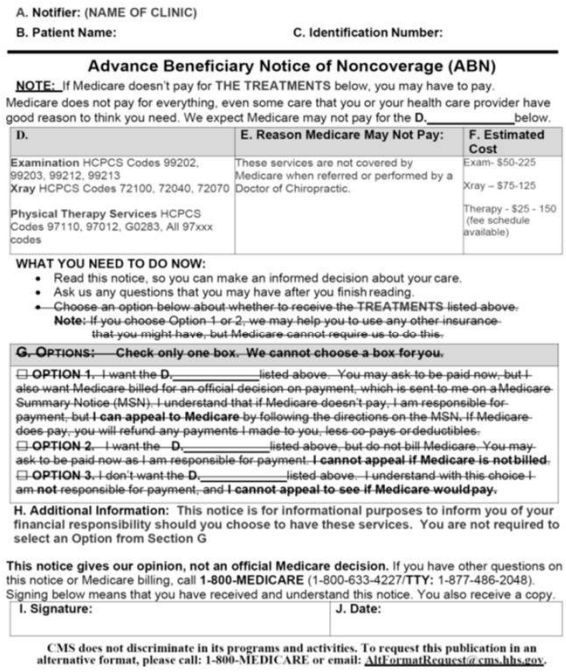
Form CMS-R-131 (Exp. 06/30/2023) Form Approved OMB No. 0938-0566

EXAMPLE OF A CHIROPRACTIC ABN

REVIEW WITH PATIENT

DO NOT TELL THEM WHAT OPTION TO CHOOSE!

85



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:

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.

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

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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

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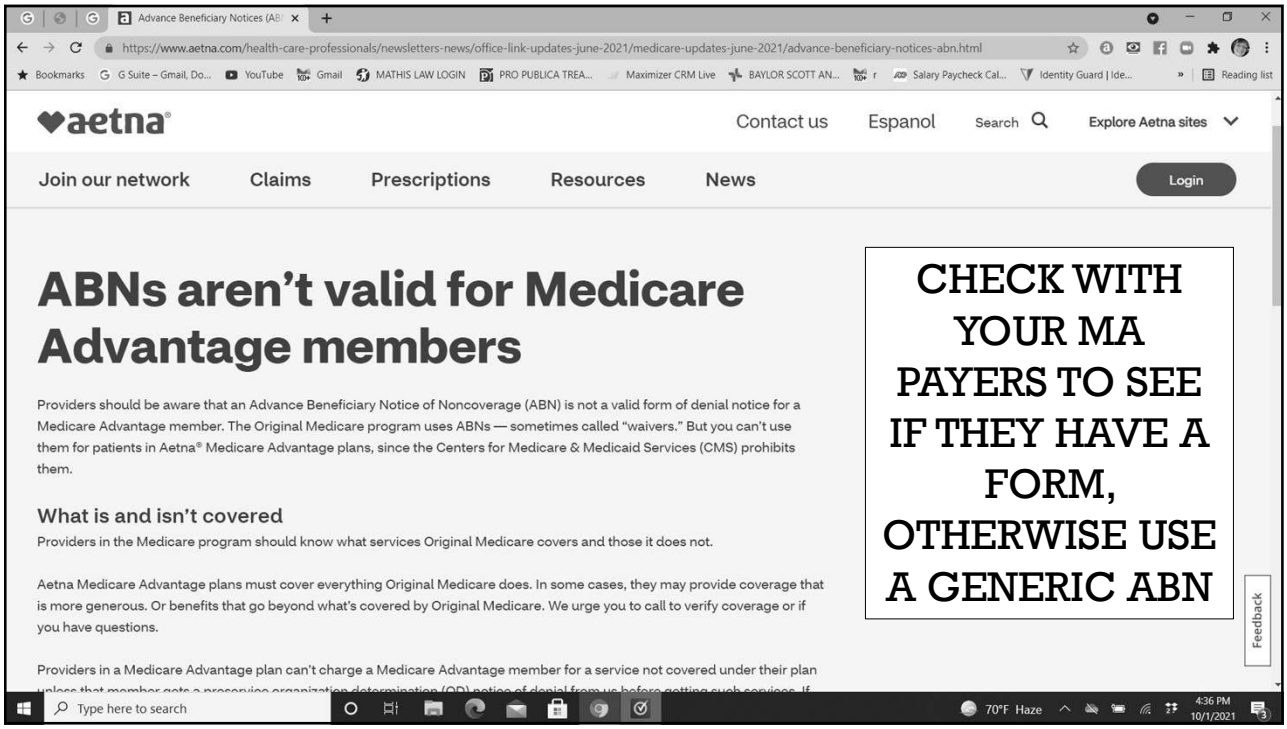
WHAT ABOUT MEDICARE ADVANTAGE PLANS?

- 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

88



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

89

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

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NEW ABN MANDATORY AS OF 6/30/2023

- The current ABN Form Expires 6/30/2023
- ALL PATIENTS under ABNs must be issued a new one by the expiration date of 6/30/23
- You may start using the new ABN form now, it is available

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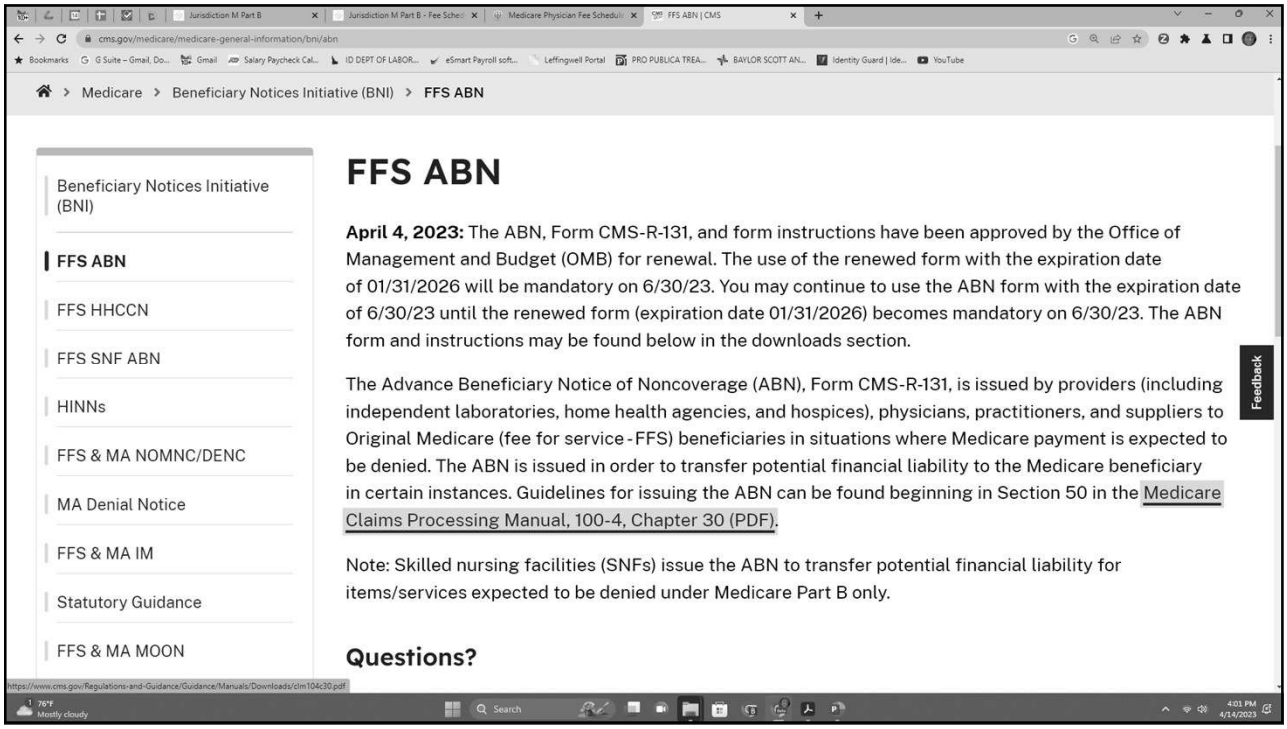

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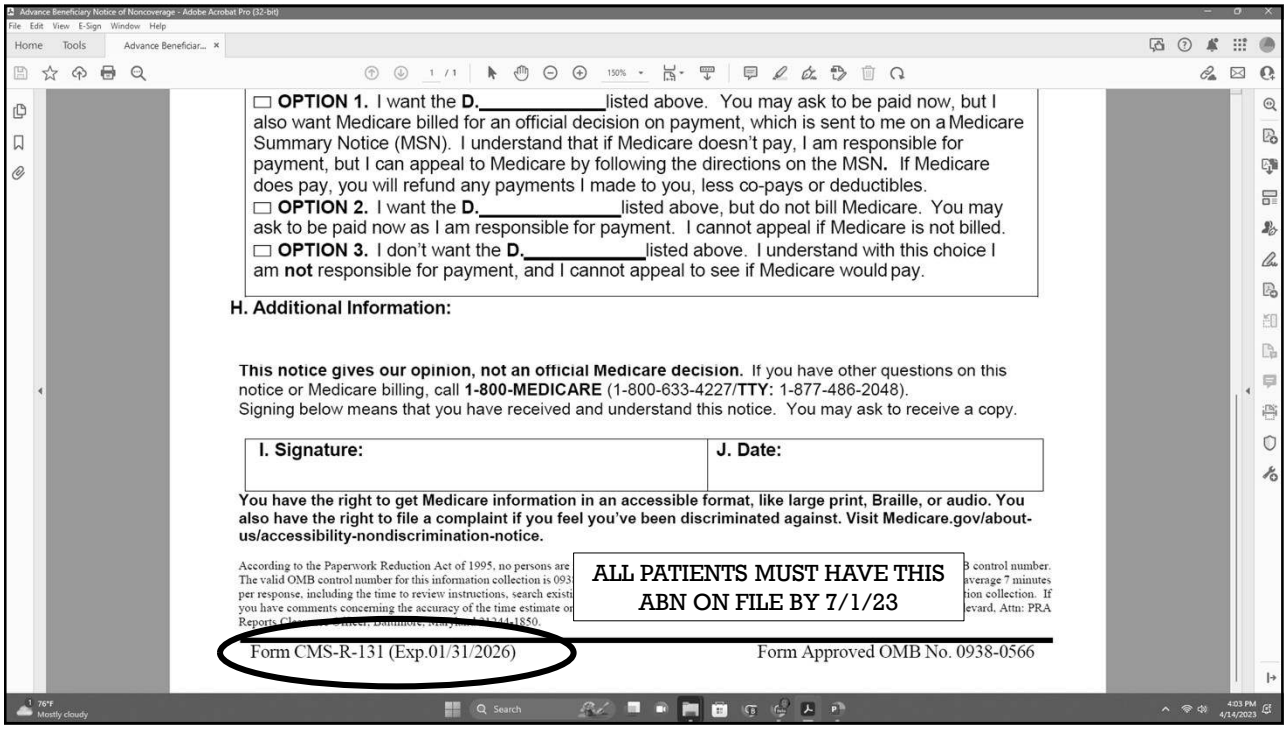

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H. Additional Information:

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 may ask to receive a copy.

I. Signature:	**J. Date:**

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are … B control number. The valid OMB control number for this information collection is 093… average 7 minutes per response, including the time to review instructions, search existi… tion collection. If you have comments concerning the accuracy of the time estimate or… evard, Attn: PRA Reports Cl… Office, Baltimore, Maryland 21244-1850.

ALL PATIENTS MUST HAVE THIS ABN ON FILE BY 7/1/23

Form CMS-R-131 (Exp.01/31/2026) Form Approved OMB No. 0938-0566

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TO OBTAIN NEW ABN TEMPLATES

- EMAIL US! LMOLINA@GOLDSTARMEDICAL.NET . Tell Liz you'd like the ABN templates!
- https://www.cms.gov/medicare/medicare-general-information/bni/abn
  - Scroll to the bottom of the page and find the window DOWNLOADS.
  - Download ABN Instructions
  - Download ABN Forms English and Spanish (ZIP)

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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**

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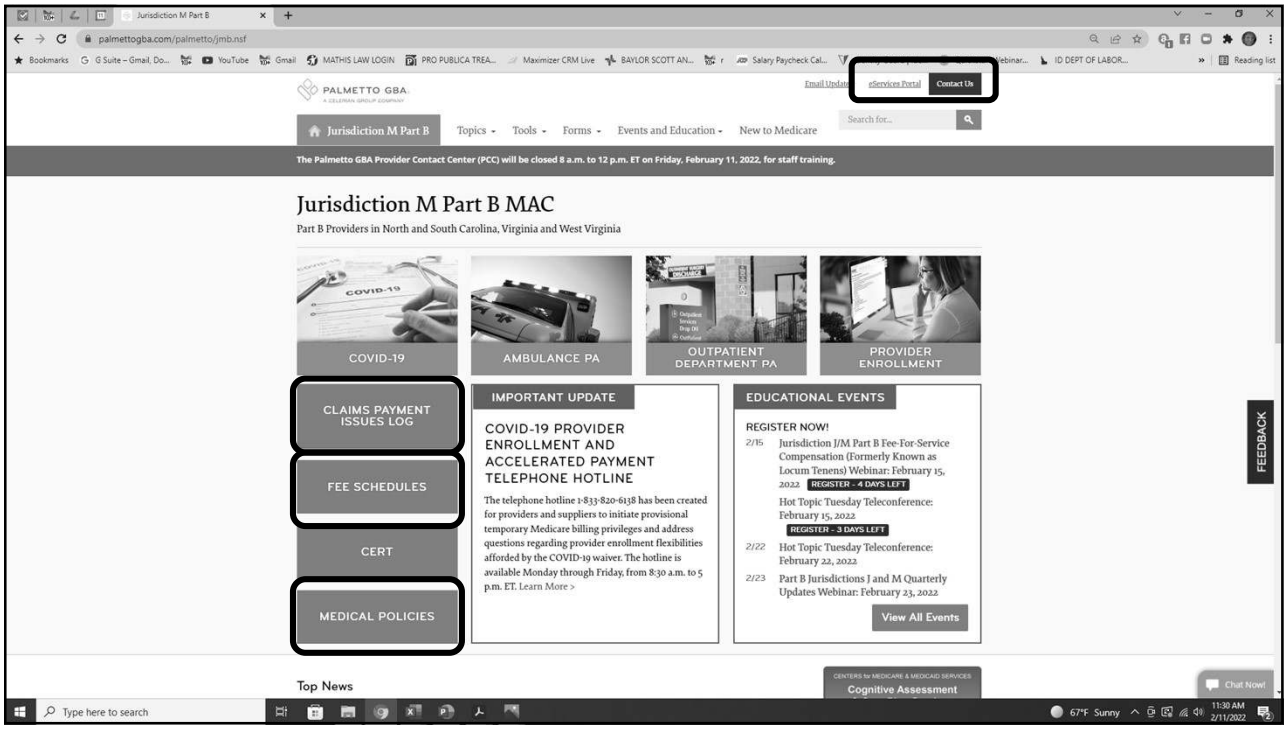
MEDICARE PROVIDER PORTALS

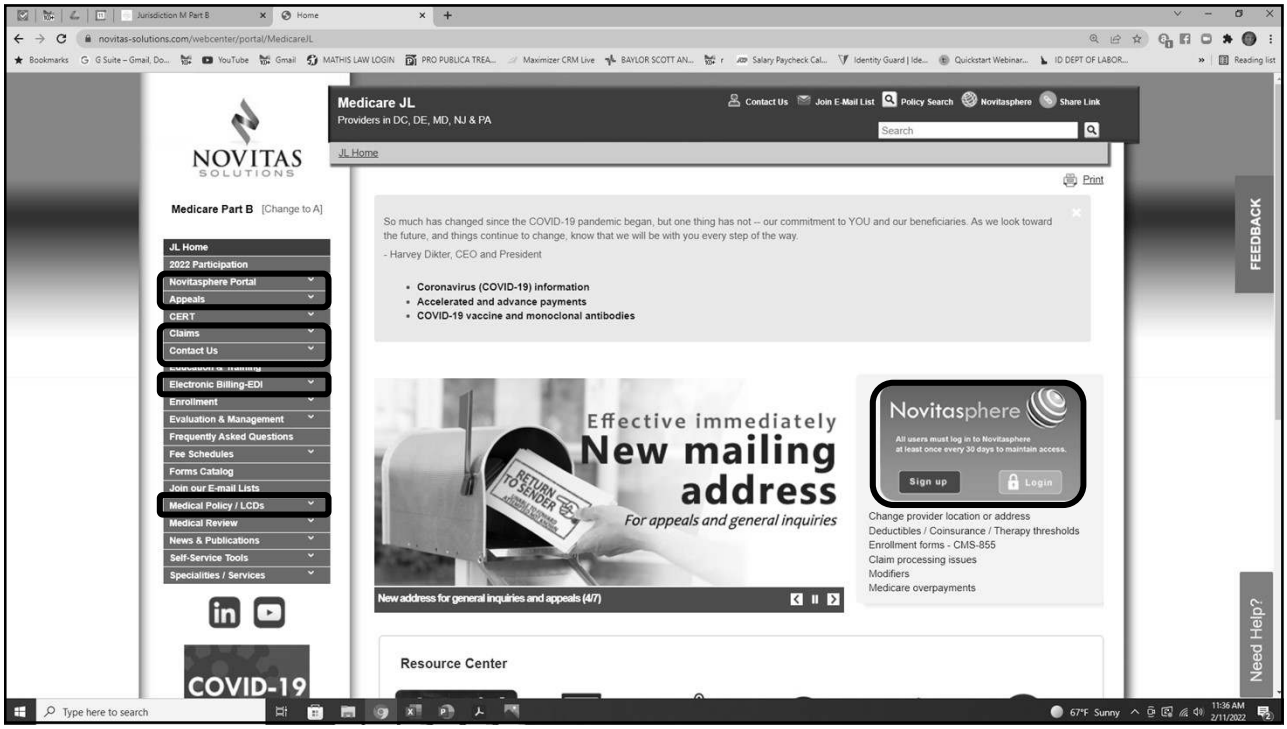
PALMETTO GBA – E-SERVICES PORTAL

NOVITAS SOLUTIONS - NOVITASPHERE

96


palmettogba.com/palmetto/jmb.nsf
PALMETTO GBA
eServices Portal
Contact Us
Jurisdiction M Part B
Topics
Tools
Forms
Events and Education
New to Medicare
Search for...
The Palmetto GBA Provider Contact Center (PCC) will be closed 8 a.m. to 12 p.m. ET on Friday, February 11, 2022, for staff training.
Jurisdiction M Part B MAC
Part B Providers in North and South Carolina, Virginia and West Virginia
COVID-19
AMBULANCE PA
OUTPATIENT DEPARTMENT PA
PROVIDER ENROLLMENT
CLAIMS PAYMENT ISSUES LOG
FEE SCHEDULES
CERT
MEDICAL POLICIES
IMPORTANT UPDATE
COVID-19 PROVIDER ENROLLMENT AND ACCELERATED PAYMENT TELEPHONE HOTLINE
The telephone hotline 1-833-820-6138 has been created for providers and suppliers to initiate provisional temporary Medicare billing privileges and address questions regarding provider enrollment flexibilities afforded by the COVID-19 waiver. The hotline is available Monday through Friday, from 8:30 a.m. to 5 p.m. ET. Learn More >
EDUCATIONAL EVENTS
REGISTER NOW!
2/15 Jurisdiction J/M Part B Fee-For-Service Compensation (Formerly Known as Locum Tenens) Webinar: February 15, 2022 REGISTER - 4 DAYS LEFT
Hot Topic Tuesday Teleconference: February 15, 2022 REGISTER - 3 DAYS LEFT
2/22 Hot Topic Tuesday Teleconference: February 22, 2022
2/23 Part B Jurisdictions J and M Quarterly Updates Webinar: February 23, 2022
View All Events
FEEDBACK
Top News
Cognitive Assessment
Chat Now!
Type here to search
67°F Sunny
11:38 AM
2/11/2022

97


novitas-solutions.com/webcenter/portal/MedicareJL
NOVITAS SOLUTIONS
Medicare JL
Providers in DC, DE, MD, NJ & PA
Contact Us
Join E-Mail List
Policy Search
Novitasphere
Share Link
Search
JL Home
Print
Medicare Part B [Change to A]
JL Home
2022 Participation
Novitasphere Portal
Appeals
CERT
Claims
Contact Us
Electronic Billing-EDI
Enrollment
Evaluation & Management
Frequently Asked Questions
Fee Schedules
Forms Catalog
Join our E-mail Lists
Medical Policy / LCDs
Medical Review
News & Publications
Self-Service Tools
Specialities / Services
COVID-19
So much has changed since the COVID-19 pandemic began, but one thing has not -- our commitment to YOU and our beneficiaries. As we look toward the future, and things continue to change, know that we will be with you every step of the way.
- Harvey Dikter, CEO and President
Coronavirus (COVID-19) information
Accelerated and advance payments
COVID-19 vaccine and monoclonal antibodies
Effective immediately
New mailing address
For appeals and general inquiries
New address for general inquiries and appeals (4/7)
Novitasphere
All users must log in to Novitasphere at least once every 30 days to maintain access.
Sign up
Login
Change provider location or address
Deductibles / Coinsurance / Therapy thresholds
Enrollment forms - CMS-855
Claim processing issues
Modifiers
Medicare overpayments
Resource Center
FEEDBACK
Need Help?
Type here to search
67°F Sunny
11:36 AM
2/11/2022

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PALMETTO GBA E-SERVICES PORTAL AND NOVITASPHERE

- 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

99

MEDICARE CLAIMS INVESTIGATIONS

100

Medicare Parts A & B Appeals Process

101

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

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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)

103

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.

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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.

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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.

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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

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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

108

MEDICARE AUDITS

109

PRE-PAYMENT AUDIT

- CLAIM IS AUDITED BEFORE PAYMENT IS ISSUED.
- USUALLY AUTOMATED-CONDUCTED DURING THE CLAIMS PROCESSING PHASE
- RESULTS IN CLAIMS REJECTION (RTP)
- SOME PRE-PAYMENT AUDITS WILL RESULT IN A MEDICAL RECORDS REQUEST

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CERT (COMPREHENSIVE ERROR RATE TESTING) AUDIT

- The Comprehensive Error Rate Testing (CERT) Program, established by the Centers for Medicare & Medicaid Services (CMS), calculates error rates that measure both the extent to which providers are correctly submitting claims to Medicare and the extent to which contractors (including Palmetto GBA) are correctly paying claims

- Every month, the CERT contractor selects a random sample of both paid and denied claims processed by Palmetto GBA. The CERT Contractor sends letters to the providers who submitted those claims, requesting medical records and any additional documentation that will support the service(s) that were provided.

https://www.palmettogba.com/palmetto/jmb.nsf/DIDC/8EEL8R5556~Specialties~Chiropractic

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CERT (COMPREHENSIVE ERROR RATE TESTING) AUDIT

•

Chiropractic Medical Records and Documentation
Medicare requires the individual who ordered or provided services be clearly identified in the medical records. The signature for each entry must be legible and should include the practitioner's first and last name and applicable credentials, e.g., P.A., D.O. or M.D. For more information about signatures, please refer to "Medicare Medical Records: Signature Requirements, Acceptable and Unacceptable Practices" and CMS MLN Fact Sheet Complying with Medicare Signature Requirements (PDF, 838 KB).

When the CERT Contractor requests documentation from doctors of chiropractic medicine, the request letter will contain specific instructions to provide records/documentation for the preceding six months prior to the date of service for the sampled claim(s), if the services in those six months are associated with the same condition(s). When you submit documentation to the CERT Contractor in response to their request, it is imperative that you include the treatment plan to support chiropractic services planned and rendered for the course of treatment.

https://www.palmettogba.com/palmetto/jmb.nsf/DIDC/8EEL8R5556~Specialties~Chiropractic

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FOLLOW THE DOCUMENTATION REQUIREMENTS CONTAINED IN THE CHIROPRACTIC JOB AID

THEY ARE THE SAME REQUIREMENTS THAT ARE REVIEWED IN CERT AUDITS

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COMMON ERRORS FOUND IN CERT AUDITS OF CHIROPRACTIC CLAIMS

Common denials seen by Palmetto from CERT contractor reviews of Chiropractic care are as follows:

- Missing treatment plan (PLAN OF CARE)
- Chief Complaint is not clearly documented
- Regions being treated are not clearly documented
- Subluxation Levels not Defined

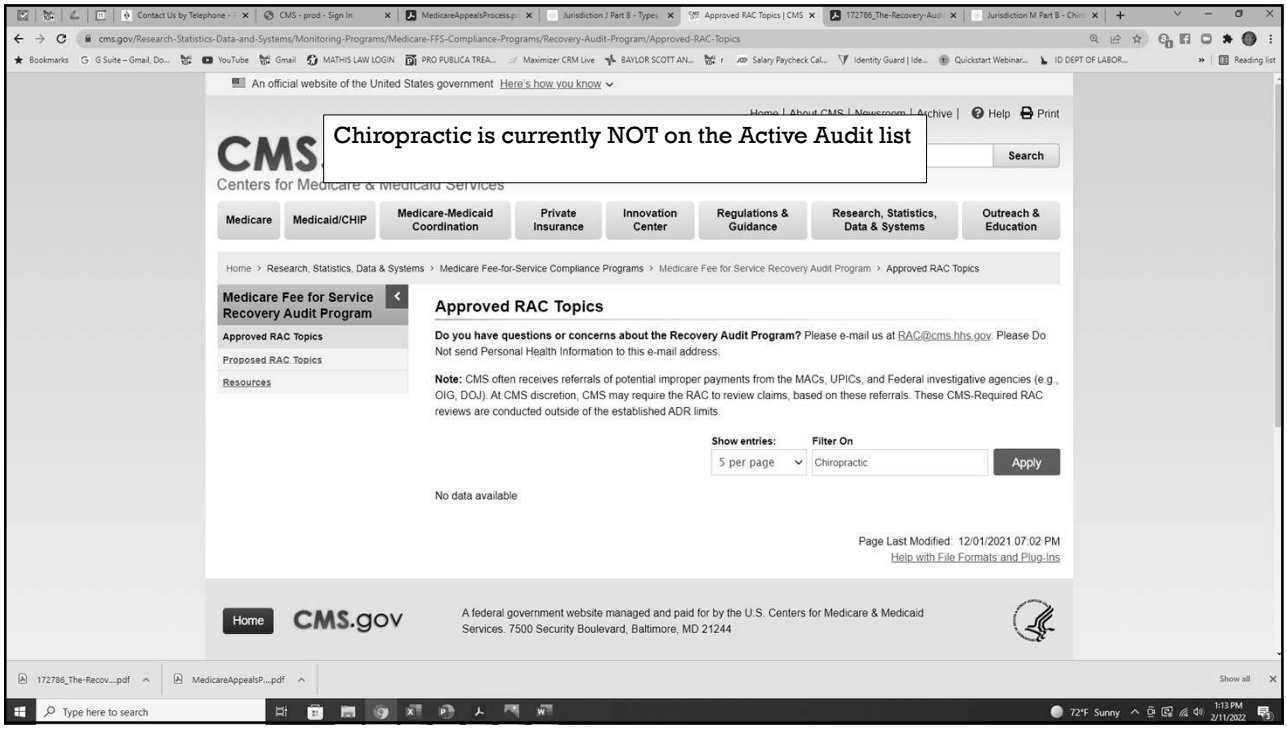
To avoid denial of your claim(s) requested, follow the documentation guidelines previously stated. All the requested documentation must be submitted to the CERT Contractor by the deadline stated in the request. If your claim is found in error Palmetto GBA is required to recoup any payment(s) that may have been made on the claim(s).

114

RECOVERY AUDIT CONTRACTORS (RAC)

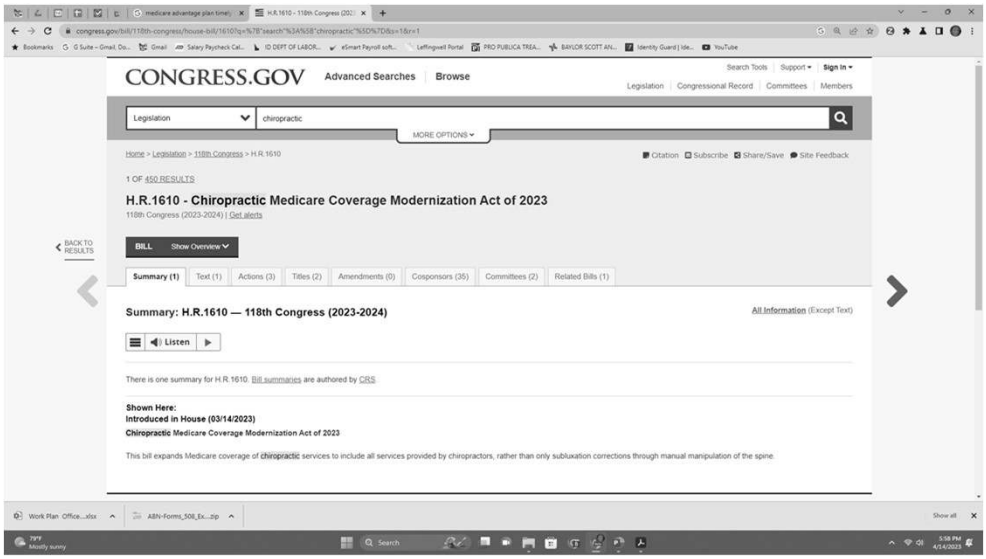
- RAC Audits usually target a specific area of Fraud, Waste and/or Abuse of the Medicare System
- Many times RAC Audits follow in the wake of the OIG Work Plans
- Much more comprehensive than CERT Audits
- Longer Look Back Period
- Extrapolation Audit
- CMS.GOV has a list of ACTIVE RAC audit topics

115



116

FEDERAL LEGISLATION AFFECTING CHIROPRACTIC



117

YOUR CONGRESSMEN

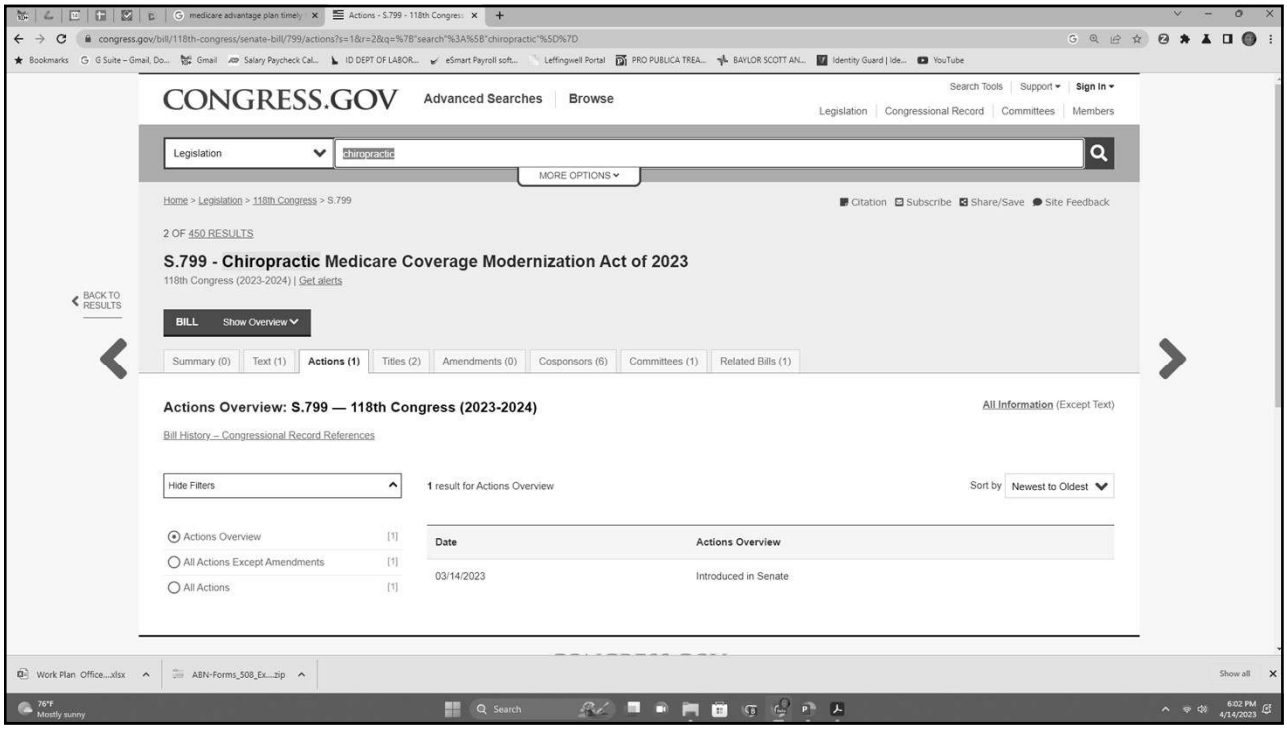
Representatives of the 118th United States Congress:

- 1st district: Rob Wittman (R) (since 2007)
- 2nd district: Jen Kiggans (R) (since 2023)
- 3rd district: Bobby Scott (D) (since 1993)
- 4th district: Jennifer McClellan (D) (since 2023)
- 5th district: Bob Good (R) (since 2021)
- 6th district: Ben Cline (R) (since 2019)
- 7th district: Abigail Spanberger (D) (since 2019)
- 8th district: Don Beyer (D) (since 2015)
- 9th district: Morgan Griffith (R) (since 2011)
- 10th district: Jennifer Wexton (D) (since 2019)
- 11th district: Gerry Connolly (D) (since 2009)

Contact Information for your Congressman/Woman

https://www.congress.gov/members

118



119

YOUR SENATORS

- Tim Kaine
  https://www.kaine.senate.gov/contact
- Mark Warner
  https://www.warner.senate.gov/public/

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QUESTIONS?

CONCERNS?

NEED HANDOUTS?

NEED FORMS?

NEED ADVICE?

NEED HELP?

BILLING SERVICES
TRAINING
CREDENTIALING
CONSULTING
COMPLIANCE

UVCA MEMBER BENEFIT

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UVCA
SAVE THE DATE!
DEC 2, 2023 (SATURDAY)
9AM – 5PM

Live, IN PERSON Medicare Billing and Documentation Course

Northern VA- Location TBA

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THANK YOU FOR YOUR ATTENDANCE!

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