

Chiropractic Coding & Compliance Alert

Reimbursement: Know the Three Essential Facts About Opting Out From Medicare

Never decide ABN options for the patient, or file claims for unusual services, and more.

Are you tired of complying with endless Medicare regulations, billing requirements, and documentation requirements?

"Yes, I believe that most providers would opt out of Medicare due to all of the requirements. But keep in mind that all payers follow Medicare guidelines and requirements; so opting out may not get providers anywhere," explains **Doreen Boivin, CPC, CCA**, with Chiro Practice, Inc., in Saco, Maine.

How many times have you thought to give it up by hoping to opt out of Medicare, only to find that chiropractic physicians are not allowed to do so? Perhaps the only way to avoid Medicare requirements is to not see a Medicare beneficiary at all.

"Providers can simply say they are not taking Medicare patients at this time," adds Boivin. However, "they cannot deny a Medicare patient treatment. They can merely regulate the percentage of patients from certain payer mixes so that they are not top-heavy in one payer versus the other."

According to the plentiful literature disseminated by Medicare, you have to abide by the Medicare regulations while treating a Medicare eligible patient. Here are some of the rules:

1. Medicare requires physicians to submit claims for all covered services within one year from date of service.
2. Acute, chronic, and maintenance adjustments are all covered services.
3. Medicare requires that an ABN be obtained from a patient when rendering a covered service you feel will be denied.
4. Medicare requires claims submission when a Medicare eligible patient requests that the service be billed.

Differentiate Between Covered vs. Reimbursable Services

Did you know that there is a lot of difference between a covered service and a service that is reimbursable? This is well explained in the document "ICN 906143 October 2013" from CMS:

"What are the covered chiropractic services under Medicare? Spinal manipulation is a covered service under Medicare. Acute, chronic, and maintenance adjustments are all 'covered' services, but only acute and chronic services are considered active care and therefore, may be reimbursable. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment moves from corrective to supportive in nature, the treatment is then considered maintenance therapy."

To firm it up, Boivin emphasizes that "maintenance care is not a covered service; they state it right in the document. A supportive treatment is considered as maintenance therapy and it will not be covered."

Follow ABN Do's and Don'ts

Do not be misled by the false security or a blanket cover that an ABN (Advance Beneficiary Notice) seems to provide in the first impression. CMS mentions it in one of the FAQ sections on ABNs. The question asks whether you must submit a claim to Medicare even if you know the service will be denied and the beneficiary has agreed to pay. Medicare's response is, "This is one of the purposes of the Advance Beneficiary Notice (ABN). If you have a covered service you feel will be denied, you would present an ABN to the beneficiary. If they choose Option #1, yes, you would still be required to submit a claim. If the beneficiary chooses Option #2, then you would not be able to submit a claim."

Remember: Please note that Medicare ABN rules state that providers are prohibited from preselecting options on the ABN for the patient, and that "the patient or authorized representative is to personally select an option." (Chapter 30 of the Medicare Claims Processing Manual, 70.4.4)

"The ABN is very confusing for staff and providers alike," admits Boivin. The instructions for this form have gone back-and-forth over the many years that I have been in this field."

Explore the Exceptions to Mandatory Claim Filing

CMS's Medicare Enrollment and Claim Submission Guidelines emphasize the requirement to bill for the services rendered. A claim is defined as a request for payment for benefits or services received by a beneficiary. When you furnish covered services to Medicare beneficiaries, you are required to submit claims for your services and should not charge beneficiaries for completing or filing Medicare claims. MACs monitor compliance with these requirements. Offenders may be subject to a Civil Monetary Penalty of up to \$10,000 for each violation.

Exceptions to mandatory claim filing: According to a CMS MLN® article on Medicare Claims Submission guidelines (ICN906764), you are not required to file claims on behalf of Medicare beneficiaries when:

- The claim is for services for which Medicare is the secondary payer;
- The primary insurer's payment is made directly to the beneficiary;
- The beneficiary has not furnished the primary payment information needed to submit the Medicare secondary claim;
- The claim is for services furnished outside the United States (U.S.);
- The claim is for services initially paid by a third-party insurer who then files a Medicare claim to recoup what Medicare pays as the primary insurer (for example, indirect payment provisions);
- The claim is for other unusual services, which are evaluated by MACs on a case-by-case basis;
- The claim is for non-covered services, unless the beneficiary requests submission of a claim to Medicare (a supplemental insurer who pays for these services may require a Medicare claim denial notice prior to making payment);
- The beneficiary signed a Beneficiary Notice of Noncoverage, indicating that no claim should be filed for a specific item or service;
- You opted-out of the Medicare Program and entered into a private contract with the beneficiary (when you opt-out of Medicare and privately contract with a beneficiary for the purpose of furnishing items or services that would otherwise be covered, you cannot submit a claim for such services) You have been excluded or debarred from the Medicare Program (when you have been excluded or debarred from the Medicare Program, you cannot submit a claim for your services).

Note: Remember, Federal Law precludes chiropractors from opting out of Medicare.

Road ahead: These CMS documents, and others, clearly demonstrate that if you happen to treat a Medicare beneficiary, you would invariably end up being accountable to Medicare, as the payment to your services would be looked after by them.

"Be aware of the guidelines, know what is expected, and follow them specifically," advises Boivin. "If you have questions, ask a Medicare representative."