

Spring Medicare Update 2011

Who does Money Tree Billing, LLC turn to for the latest in Medicare compliance information? Ron Short, DC, MCS-P, is a certified insurance consultant, certified peer review specialist, and certified medical compliance specialist. Dr. Short is one of the first of a new breed of chiropractic consultants; a chiropractor with practice experience trained and certified to address and solve compliance problems. He has received ChiroCode Institute's highest recommendation as a consultant and speaker. Following is Dr. Short's point-by-point summary of recent Medicare changes. It's been a great source of reference for our team and we wanted to share it with yours.

New Medicare Enrollment Procedures

- On September 23, 2010 CMS published some proposed rules in the Federal Register for comment.
- The comment period ended November 15, 2010.
- The final rules were published February 2, 2011.
- The rules will be effective March 25, 2011 for all new Medicare enrollees and for current enrollees that are re-validating.
- The rules will be effective for all current enrollees March 25, 2012.

The rules are as follows:

- **Screenings** to include:
 - Verification of Medicare specific requirements.
 - License verification.
 - Database checks.
 - Unscheduled/unannounced site visits.
 - Criminal background checks.
 - Fingerprinting.
- There are three categories of screenings.
 - Limited.
 - Moderate.
 - High.
- "Physician and non-physician practitioners and medical groups and clinics" will be placed in the limited category. The limited category includes:
 - "Verification of any provider/supplier specific requirements established by Medicare."
 - "Conduct license verifications (may include licensure checks across states)".
 - "Database Checks to verify Social Security Number (SSN), the National Provider Identifier (NPI), the National Practitioner Data Bank (NPDB) licensure, an OIG exclusion, taxpayer identification number, tax delinquency, death of an individual practitioner, owner, authorized official, delegated official, or supervising physician."
- A specific provider type can be moved from "limited" to "high" for two reasons:
 - If CMS believes that the specific provider type poses a greater risk of fraud, waste or abuse.
 - If the specific provider type has been under a temporary moratorium.

- Temporary moratoria on enrollment of Medicare Providers and Suppliers, Medicaid and CHIP Providers
 - The Secretary of Health and Human Services may impose temporary moratoria on the enrollment of new Medicare, Medicaid or CHIP providers and suppliers, including categories of providers and suppliers if the secretary determines such moratoria are necessary to prevent or combat fraud, waste or abuse under the programs.
 - The moratorium will be imposed for 6 months and extended in 6-month increments, as CMS deems necessary.
 - The moratorium can be appealed through the Departmental Appeals Board level.
 - Moratoria will be announced in the Federal Register and through the Medicare listserv.
- Suspension of payments
 - CMS can suspend payments to a provider when there is a credible allegation of fraud.
 - It is proposed that CMS consult with the OIG and/or the Department of Justice to determine if there is a credible allegation of fraud.
- Application Fees
 - For the purpose of the Affordable Care Act, CMS has determined that physicians are exempt from the payment of application fees.
- If a provider or supplier is terminated from Medicare they will now be terminated from Medicaid and CHIP.
 - It also works the other way.
 - If a provider is terminated from Medicaid or CHIP then they will also be terminated from Medicare.
- The Federal Register article was in three parts. To find them go to: <http://www.gpoaccess.gov/fr/>. And search for "Medicare Enrollment". From there download the PDF from the first three selections.

Recommendations

Medicare is trying to get everyone to re-enroll through the online PECOS system. If you do so before March 23 you will not have to undergo the new screening procedures. I recommend that if you have not done so already that you re-enroll in the PECOS system. You can find the PECOS system here: <https://pecos.cms.hhs.gov/pecos/login.do>.

Clinical review Judgment

- On June 15, 2010 CMS implemented the Clinical Review Judgment effective for MACs, RACs, CERT, PSCs and ZPICs.
- The Clinical Review Judgment has two steps:
 - The synthesis of all submitted medical record information (e.g., progress notes, diagnostic findings, medications, nursing notes) to create a longitudinal clinical picture of the patient.
 - The application of this clinical picture to the review criteria to make a reviewer determination on whether the clinical requirements in the relevant policy have been met.
- The Clinical Review Judgment process is to be used when making complex medical review determinations about a claim.
- The purpose of this change is to better “standardize” the review process.
- This gives us another tool to help the doctor survive a review.
- The doctor can now submit the additional documentation necessary to develop a complete picture of the patients’ condition and it **must** be considered.
- You can find the regulation here: <http://www.cms.gov/manuals/downloads/pim83c03.pdf>.

Recommendations

When responding to requests for records include the re-exam after the date of service in question. This information is needed to prove that there is improvement but it is not usually requested. If you include it, it must be considered. If it is not considered you will have a good case for appeal.

E-Prescribing Hardship Codes

- If you are not a successful E-Prescriber your Medicare payments will be cut by 1% next year (2012).
- Since chiropractors do not have prescribing privileges we qualify to use a hardship code to exempt ourselves from the payment reduction.
- The code must be reported one time between January 1 and June 30 2011.
- Place the code **G8644** in blank 24D of the CMS 1500 form (or the electronic equivalent).
- Place \$0.00 in blank 24F of the CMS 1500 form (or \$0.01 if your electronic billing program will not allow for a \$0.00 amount).
- You will receive a denial for this code. Do not do anything more than file the denial to prove that you submitted the code. This denial should not count as an error
- Once you have done this you will not be considered for a payment reduction next year.

“In 2012, the Physician Fee Schedule amount for covered pro-

fessional services furnished by an eligible professional who is not a successful electronic prescriber will be reduced by 1 percent. CMS introduced new codes referred to as hardship codes, to be reported at least one time on a denominator-eligible claim during the *2012 payment adjustment reporting period (January 1 through June 30, 2011)*, if applicable. These codes are to be used **ONLY** when an eligible professional wishes to request a significant hardship exemption from the application of the 2012 payment adjustment because the professional is unable to submit prescriptions electronically due to a system hardship (e.g., rural without internet, limited available pharmacies for electronic prescribing, or does not have prescribing privileges). Hardship codes are represented by the G-codes listed below.

If a hardship applies to you, below, are the two hardship G-codes from which eligible professionals may choose.

G8642: The eligible professional practices in a rural area without sufficient high speed internet access and requests a hardship exemption from the application of the payment adjustment under section 1848(a)(5)(A) of the Social Security Act

G8643: The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing and requests a hardship exemption from the application of the payment adjustment under section 1848(a)(5)(A) of the Social Security Act.

Payment Adjustment

Another reporting option: When the eligible professional does not have prescribing privileges, report **G8644** via claims. If this code is utilized, the eligible professional may not be considered for a payment adjustment.”

Recommendations

Use this code once between now and June 30.

Signatures

- Medicare now requires signatures on all notes. Initials are no longer acceptable. Signature stamps are not acceptable.
- Records that are not signed are being denied on review.
- The National Committee for Quality Assurance Guidelines for Medical Record Review recommends that all consultation, lab and imaging reports filed in the patient’s chart be initialed by the doctor who ordered them.
- At this time there are no Medicare regulations regarding electronic signatures therefore HIPAA regulations apply.
- I recommend that the doctor sign all daily notes and that all reports be signed by the ordering doctor with the notation “read and reviewed”.
- Signature information can be found in the Medicare Program Integrity Manual, Chapter 3, Section 3.4.1.1(D).
- That can be found at: <http://www.cms.gov/manuals/downloads/pim83c03.pdf>.

ABN

- Effective January 12, Medicare reviewers will be requesting ABNs as part of the Additional Documents Request when performing Complex Medical reviews.
- The ABN must be completed in accordance with Section 50.6.3 of Chapter 30 of the Medicare Claims Processing Manual, which you can find here: <http://www.cms.gov/manuals/downloads/clm104c30.pdf>.
- If the reviewer finds that the claim is reasonable and necessary then they will perform a face validity assessment of the ABN.
- This regulation applies to all MAC, RAC, ZPIC and CERT reviewers.
- This change is documented in Section 3.15 of Chapter 3 of the Medicare Program Integrity Manual.
- You can find it here: <http://www.cms.gov/manuals/downloads/pim83c03.pdf>.

Durable Medicare Equipment

While it is legal for chiropractors to become DMEPOS (Durable Medical Equipment Prosthetics and Orthotics Suppliers) just as it is legal for anyone else, I recommend that you carefully reconsider if you are contemplating such an action. Many doctors erroneously believe that becoming a DME supplier is a way to get Medicare to pay for orthotics and supports. Others believe that this would be a good second business. Either way, you should consider the following before you take such an action:

- DMSPOS suppliers are under more scrutiny than ever before. Almost weekly there are reports of DME suppliers arrested for Medicare fraud.
- Newly enrolling DME suppliers must undergo High-level screenings including criminal background checks and fingerprinting.
- Stark law prevents you as a doctor from referring a patient to your DME company.
- As a chiropractor you cannot refer a Medicare patient for anything but an adjustment.

I am not against chiropractors becoming DME suppliers but you must be fully informed before you take such an action. Someone who is selling you a program may not give you all of the information that you need so conduct due diligence before you act.

Mandatory Office Compliance Program

- “A provider of medical or other items or services or a supplier shall, as a condition of enrollment in Medicare, Medicaid or CHIP, establish a compliance program that contains certain “core elements”
- The seven elements of an effective compliance and ethics

program described in the Federal Sentencing Guidelines are proposed to be used as the basis for the “core elements” of the required compliance program for Medicare. These elements are:

1. The development and distribution of written policies, procedures and standards of conduct to prevent and detect inappropriate behavior.
2. The designation of a chief compliance officer and other appropriate bodies (for example a corporate compliance committee) charged with the responsibility of operating and monitoring the compliance program and who report directly to high-level personnel and the governing body.
3. The use of reasonable efforts not to include any individual in the substantial authority personnel whom the organization knew, or should have known, has engaged in illegal activities or other conduct inconsistent with an effective compliance and ethics program.
4. The development and implementation of regular, effective education and training programs for the governing body, all employees, including high-level personnel, and, as appropriate, the organization’s agents.
5. The maintenance of a process, such as a hotline, to receive complaints and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation.
6. The development of a system to respond to allegations of improper conduct and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or Federal health care program requirements.
7. The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas.
8. The investigation and remediation of identified systemic problems including making any necessary modifications to the organization’s compliance and ethics program.

- The proposed rules for the Office Compliance Program will be published for comment again with the comments already received in a upcoming Federal Register. Given the timeline of the other rules the earliest that we can expect a final rule will be about August.
- The Mandatory Office Compliance Program will be implemented later than the other changes to Medicare enrollment.
- You can find the Federal Register article here: <http://edocket.access.gpo.gov/2010/pdf/2010-23579.pdf>.

What does it take to establish an effective Office Compliance Program?

- Review of the facility.
- Review of HIPAA manual and procedures.
- Review of OSHA manual and Exposure Plan.
- Review of office procedures and policies.
- Review of 10 randomly selected records for each doctor with 5 of the records from Medicare patients.
- Review of the claims for the selected records.
- Review of the EOBs for the selected records.
- As a result of these reviews you will receive:
 - A list of deficiencies identified for the facility with recommended corrections.
 - A list of deficiencies identified for the documentation with recommended corrections.
 - A compliance manual for your practice.
 - An office compliance program is customized to each office.
 - Due to the detailed nature of the office compliance program it cannot be put into a standardized format.
 - You will need a certified Medical Compliance Specialist to develop an effective Office Compliance Program.

Recommendation

Schedule your office compliance audit today while time slots are available.



Dr. Short offers the following services:

- Free e-mail Medicare alerts and updates. To be added to Dr. Short's mailing list simply e-mail him at drron1085@gmail.com and request to be added to his list.
- "Medicare for Chiropractors". A comprehensive book on Medicare procedures for chiropractors designed to be both a training and reference resource.
- Records Reviews. Review of individual records or a group of records to help you identify and correct documentation errors.
- Compliance Audits. A complete on-site audit of you office, procedures, policies and records. This is the best protection that you can have against Medicare audits and reviews.

To request any of these options or for more information call Dr. Short at 217-285-2300 or e-mail him at drron1085@gmail.com



Money Tree Billing, LLC.

Your Chiropractic Billing Team

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Your Chiropractic Billing Team

Our goal is your success...

- A stress-free alternative to in-house billing
- Saves you time & overhead costs
- Allows you to remain patient-focused
- Our "No Claim Left Behind Guarantee" means you have nothing to lose!

"What sets them apart from all other billing services is that they have STRONG chiropractic philosophy and they have been billing chiropractic claims, not medical claims for years. They walk their talk and they will be in your corner all of the way."

~Dr. Keith Billstein, Chiropractor

Schedule a no-obligation consultation today!

763-331-0358



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