Billing & Coding II ~ Medicare & ICD-10 (4 hrs) ~ David Hofheimer, D.C., Esq.
Back to Chiropractic CE Seminars

Welcome:
This course is approved for 4 Hours of CE for Billing & Coding II ~ Medicare & ICD-10 for the Chiropractic Board of Examiners for the state of California.

There is no time element to this course, take it at your leisure. If you read slow or fast or if you read it all at once or a little at a time it does not matter.

How it works:

1. **Helpful Hint: Print exam only and read through notes on computer screen and answer as you read.**
2. **Printing notes will use a ton of printer ink, so not advised.**
3. **Read thru course materials.**
4. **Take exam; e-mail letter answers in a NUMBERED vertical column to marcusstrutzdc@gmail.com.**
5. **If you pass exam (70%), I will email you a certificate, within 24 hrs, if you do not pass, you must repeat the exam. If you do not pass the second time then you must retake and pay again.**
6. **If you are taking the course for DC license renewal you must complete the course by the end of your birthday month for it to count towards renewing your license. I strongly advise to take it well before the end of your birthday month so you can send in your renewal form early.**
7. **Upon passing, your Certificate will be e-mailed to you for your records.**
8. **DO NOT send the state board this certificate.**
9. **I will retain a record of all your CE courses. If you get audited and lost your records, I have a copy.**

The Board of Chiropractic Examiners requires that you complete all of your required CE hours BEFORE you submit your chiropractic license renewal form and fee.

NOTE: It is solely your responsibility to complete the course by then, no refunds will be given for lack of completion.

Enjoy,
Marcus Strutz DC
CE Provider
Back To Chiropractic CE Seminars

Objective of this seminar -

Complying with the State of California Chiropractic Act and its associated Rules and Regulations generally speaking is not hard to do. More often than not, compliance involves thinking before doing, and having enough common sense to know when to read the Act, Rules, and Regulations when being suspicious that a given course of action might be at issue. Fortunately, most chiropractors are blessed with a high degree of common sense.

The State of California Rules and Regulations are contained in Title 16 of the California Code of Regulations, Division 4, beginning with section 301. These are posted on the State of California Board of Chiropractic Examiner's ("Board") website, and are periodically updated. It is best to periodically browse these rules and regulations to make sure you are compliant in your professional life with them.

In previous years, the California Board of Chiropractic Examiners posted their mission statement on their website, which was centered upon protecting consumers from three main areas of focus - lack of competence, negligence, and insurance fraud. Competence is having and utilizing the degree of knowledge, skill, thoroughness, and training that a reasonable doctor of chiropractic would use in the performance of their professional duties. Negligence is conduct that falls below the standard of care that an objective, reasonable doctor of chiropractic would use in their professional practice. Insurance fraud is the intentional misrepresentation of at least one material fact, justifiably relied upon by another (the insurance company), so as to obtain the property (e.g. money) of another (the insurance company). Insurance fraud is most easily avoided by not having any bad intent, but it can be extremely helpful to prove that lack of bad intent.

This written seminar specifically focuses on a variety of billing aspects, including the ICD-10 system and a very detailed section on Medicare. There is an important need for Medicare to be clearly and concisely explained in one place, because it has not previously been done and it is the doctor's responsibility to handle Medicare issues properly.

Mankopf's Test –

When someone other than your patient is paying your bills (such as an insurance company), do you think it might be a good idea to prove that your patient actually has pain? It sure is – that would a very smart thing to do. How can you best prove your patient really has pain? Think back to 6th quarter in chiropractic college when you were taking your ortho/neuro class. Of all the malingerer tests, Mankopf's test is the only objective one, with the others being subjective. Objective means the outcome of the test is readily measureable, and subjective means the outcome is based on opinion. If a patient says they have pain on a certain part of their body, their heart rate should increase by at least 10 beats per minute over their baseline heart rate. This test is done very quickly by first listening to their heart rate at rest while the patient is sitting, then listening to the heart rate while pressing in hard on the area they say hurts. Make sure you have warned the patient that this test will hurt so that they are not surprised. When pressing hard on the painful area, you will readily hear the heart rate increase significantly faster that the baseline rate, and when you release your finger from the painful area you will hear the heart rate quickly slow down to its near baseline rate. This is the one thing you must do on the physical exam to protect yourself from a false claim of insurance fraud when there is billing to be done. Documenting this test shows that the patient really does have pain and that both you and the patient are honest. It's a lot less trouble to quickly do this test than it is to pay a hefty sum of money to a criminal defense attorney.

How Many Fee Schedules can a Doctor Have? -

The typical answer given to this question is a simple "one," but this is almost never correct. The answer and explanation to this question provides another great example that what was taught in school was not necessarily correct, and can actually be wrong. The straightforward correct answer as to how many fee schedules a doctor can have is the sum of a) all applicable fee schedules created by law plus, b) all fee schedules applicable by virtue of contract, plus c) one general fee schedule when no other fee schedules apply. Fee schedules created by law include both Medicare (federal, when applicable) and workers' compensation (state and federal, when applicable).

The **Medicare fee schedule** only applies to those doctors of chiropractic who are enrolled in the Medicare system when they perform spinal adjustments to Medicare beneficiaries, UNLESS the Medicare enrolled doctor obtains a proper ABN form (Advance Beneficiary Notice of Non-Payment) from the Medicare beneficiary patient PRIOR to rendering spinal adjustments. Doctors can choose whether or not to be enrolled in Medicare as a provider of services or not.

For those who choose NOT to enroll in Medicare, contrary to what is incorrectly taught elsewhere they can treat any patient who wants to be treated by them including Medicare beneficiaries, but they are prohibited from submitting any billing to Medicare. When treating a Medicare beneficiary when not enrolled in the Medicare system, it is wise to print out a form with the same wording as the Advance Beneficiary Notice (ABN) form (but not the ABN form itself) with option two checked and other pertinent information included on the form where appropriate, have the patient read and sign the form, and give the patient a copy of the form. This will provide the doctor with proof that the Medicare patient acknowledged that the doctor is prohibited from billing Medicare due to not being enrolled in the Medicare system in case the patient later submits their own form of a bill or receipt to Medicare. The reason for doing this is that sometimes patients submit their own billing or receipt to Medicare in an attempt to be reimbursed from that system for care they paid with their own money. The result is that Medicare sends those doctors a letter erroneously informing them that they must enroll in the Medicare system (due to having received billing or a receipt) even though that is not true provided the doctor themselves did not submit any billing. Sending Medicare a cover letter with a copy of the patient's signed ABN-like form should end that situation if and when it arises.

Doctors who are enrolled in the Medicare system as a provider of chiropractic care must generally submit billing for spinal adjustments, and are limited to collecting no more than what Medicare allows. For non-participating Medicare enrolled providers, the limiting charge in their applicable Medicare fee schedule sets the maximum amount to be collected for spinal adjustments regardless of other insurance available, UNLESS the Medicare enrolled doctor obtains a proper ABN form (Advance Beneficiary Notice of Non-Payment) from the Medicare beneficiary patient PRIOR to rendering spinal adjustments. The word "applicable" is used because the amount of the limiting charge varies with both the year and the geographical region (the particular county) of the doctor. Medicare requires that the payor of Medicare bills maintain a website that includes the official Medicare fee schedule with the limiting charges. For northern California, the payor is Noridian, and their website is www.noridianmedicare.com.

The other governmental fee schedules are the **workers' compensation fee schedules**. The California workers' compensation fee schedule is called the official medical fee schedule as listed on the California Department of Industrial Relations website, www.dir.ca.gov. This fee schedule pays a maximum amount for no more than four itemized billing codes per day, with each code having a defined maximum payable amount, with the entire set of billing codes being paid in a descending and cascading order. Each billing code is assigned a relative value unit (RVU), and payment is made at 100% of the billing code with the highest RVU subject to the fee schedule maximum for that code, then the second highest RVU billing code is similarly paid at 75% of the fee schedule maximum for that code, then the third highest RVU billing code is likewise paid at 50% of the fee schedule maximum for that code, then the lowest RVU billing code is paid at 25% of the fee schedule maximum for that code.

Each state has a separate workers' compensation fee schedule, and usually the fee schedule of the state where the injury occurred is the applicable fee schedule. For example, a doctor who treats a worker injured in Indiana where the Indiana state workers' compensation insurance applies and who later moves to California will most likely be paid according to the Indiana state workers' compensation fee schedule.

The federal workers' compensation fee schedule applies to federal employees injured on the job. An example of this situation would be a United States Postal Service employee who is injured on the job. The U.S. Dept. of Labor's Office of Workers' Compensation Programs (OWCP) administers federal workers' compensation under four federal Acts – the Federal Employee's Compensation Act (FECA), the Longshore and Harbor Workers' Compensation Act (LHWCA), the federal Black Lung Benefits Act (FBLBA), and the Energy Employees Occupational Illness Compensation Program Act (EEOICA). The OWCP Medical Fee Schedule applies to FECA, EEOICA, and LHWCA; a modified version is used for the FBLBA. The OWFP federal workers' compensation fee schedule can be accessed at https://www.dol.gov/owcp/regs/feeschedule/fee.htm.

There can be an unlimited number of fee schedules determined by contract. Each contract between a doctor and an insurance company (insurance payor) is unique from those contracts with other insurance companies (or insurance payors), and each are permissible. Some doctors choose not to be contracted with any insurance companies, and they therefore have none of this type of fee schedule. A doctor who has only one contract with an insurance company other than Medicare has one of this type of fee schedule, whereas a doctor who has four contracts each with different insurance companies other than Medicare has four fee schedules of this type. This contract type of fee schedule can be formed with health maintenance organizations (HMOs) and/or preferred provider organizations (PPOs) as well as intermediaries of HMOs and PPOs.

Every doctor has a **general, default fee schedule**, which is in addition to any other applicable fee schedules by way of law and those formed by contract. The doctor's general fee schedule applies when no other fee schedules apply.

Can Discounts be Given to Patients for Payment by Cash or Check? -

Yes, provided it is done correctly both legally and ethically - and further explanation is deserved.

Legal authority -

Other than with Medicare and federal workers' compensation insurance billing, the key legal source for health care services discounts performed in California is the California Business and Profession Code §657(b, c, & d). California B & P Code §657 only applies to insurance billing regulated by California state law. It does not apply to federal fee schedules, such as Medicare. The legislative intention when promulgating this law was to provide affordable, basic, and preventative health care to Californians in an environment where approximately 20% of the state was uninsured for health care. This law pertains to doctors of chiropractic as detailed in section d. Discounts can be given by doctors of chiropractic to their patients when the doctor has reasonable cause to believe that there will be no further payment by an insurance company for the services they render, and when the discounted payment is then made promptly to the doctor. Each of these situations needs explanation.

California Insurance Code §750(a) prohibits anyone (such as doctors) from accepting any rebate, refund, commission, or other consideration, whether in the form of money or otherwise, as compensation or inducement to or from any person for the referral or procurement of clients, cases, patients, or customers, and makes them guilty of a crime. Perhaps the best example of violations of California Ins. Code §750(a) is when a doctor and an attorney enter into an agreement for the attorney to supply personal injury patients to the doctor in exchange for the doctor discounting the amount of money the doctor will accept as payment in full.

California Insurance Code §750(b) sets the punishment of anyone convicted of §750(a) as confinement for up to one year and/or a monetary fine not to exceed $50,000.

California Board of Chiropractic Rules and Regulations §317(t) is one of the many ways to commit unprofessional conduct, and prohibits the offering, delivering, receiving or accepting of any rebate, refund, commission, preference, patronage, dividend, discount or other consideration as compensation or inducement for referring patients to any person. The discount here is limited in reference to compensation or inducement in order to obtain referrals. Violations of chiropractic rules and regulations are ethical violations, and violations of written laws are just that – violations of law.

California Board of Chiropractic Rules and Regulations §317(v) prohibits offering to waive deductibles and/or co-payments for a patient (or prospective patient) when this waiver is used as an advertising and/or marketing technique UNLESS the following mandatory written statement is included with the billing:

I/WE WAIVE CO-PAYMENT AND/OR DEDUCTIBLES. IT IS MY/OUR INTENTION TO DO THE FOLLOWING: (Indicate one choice below) –

( ) BILL THE PATIENT $_____ AFTER RECEIPT FROM YOU OF $_____.

( ) WAIVE ANY FURTHER PAYMENT FROM THE PATIENT AFTER RECEIPT FROM YOU OF $_____.

( ) IN CASES WHERE PREDETERMINATION OF INSURANCE BENEFITS IS NOT POSSIBLE, I/WE PROVIDE THE FOLLOWING WRITTEN EXPLANATION OF MY/OUR BILLING INTENTIONS:
_____
_____.

This mandatory language to be used is taken directly from the Chiropractic Board's Rules and Regulation §317(v). It is only required where the waiver of deductibles and/or co-payments is used as an advertising and/or marketing technique. As an example, telling either a prospective patient or an existing patient that you will waive their insurance deductibles and/or co-payments with the INTENTION to have them obtain chiropractic care that they might not otherwise obtain IS a marketing technique if not also advertising, and requires the written statement to be made to the insurance company at the same time bills are submitted.

California Board of Chiropractic Rules and Regulations §371(h) is another way to commit unprofessional conduct, which here is shown by conviction of any offense, whether felony or misdemeanor, involving moral turpitude (a readiness to do evil, and evil means the intention to harm others), dishonesty, physical violence or corruption.

California Board of Chiropractic Rules and Regulations §317(k) is still another aspect of unprofessional conduct, and is shown by the commission of any act involving moral turpitude, dishonesty, or corruption. Additionally, California Board of Chiropractic Rules and Regulations §317(q) deems the participation of any act of fraud or misrepresentation as unprofessional conduct. Violating any insurance code law will often if not usually be deemed moral turpitude, violate several chiropractic board rules and regulations, and result in professional discipline as well as legal trouble.

Perhaps the best example here is accepting an illegal offer from an attorney where the attorney promises to send (refer) their clients to a chiropractor on condition that the chiropractor agrees to discount the amount of money they will accept as payment in full PRIOR to all insurance companies acting on bills submitted to them. Agreeing to accept a discounted amount from the amount to be billed or that was billed PRIOR to all insurance companies that could pay acting on submitted bills violates both law and ethics, and can and should result in serious consequences (e.g. revocation of licensure) to the doctor.

As to Medicare patients, the federal Anti-Kickback statute is a criminal law that prohibits the offer and/or the actual exchange of anything of value in an effort to induce or reward the referral of federal health care program (e.g. Medicare) business. As to chiropractic, this law pertains to doctors of chiropractic who are enrolled with Medicare at the time of treatment of Medicare beneficiaries. Although this law pertains to the intention of obtaining patient referrals, it is possible that a prosecutor could consider the reduction of amounts owed by Medicare beneficiaries as an inducement or reward for continued treatment, which in turn could possibly be construed as an effort to induce or reward the referral of the same patient for continued treatment. Although this is a stretch, it is very expensive to defend oneself in a court of law. Therefore, it would be wise for enrolled doctors of chiropractic not to reduce or waive remaining amounts owed by Medicare beneficiaries, even after all insurance has acted and paid what they will. There should be no problem with taking as much time as is necessary to collect amounts owed as long as there

is not an intention to reduce or waive amounts owed by a Medicare beneficiary. In other words, the patient can pay what they are able to pay when they are able to pay if this acceptable to the doctor.

Reasonable Belief of no forthcoming insurance payment -

Having a reasonable believe that there will be no forthcoming payment by an insurance company can apply in a number of different situations. One situation could apply when the patient's insurance plan has a deductible that has not been satisfied and is not reasonably expected to be satisfied, which results in the doctor having reasonable cause to believe there will be no forthcoming insurance payment. The same reasonable cause to believe there will be no forthcoming insurance payment could apply when the patient's insurance plan pays benefits for a defined number of visits or dollar amount per calendar year which has been exhausted by already having been paid, leaving the patient with no further insurance benefit. The safest way to proceed is to wait to give any discounts until the explanation of benefits pages have been received from all insurance companies for the given patient.

Prompt payment -

As specified in section b, discounts for health care can also be given to a patient upon prompt payment. The definition of "prompt" is determined by the doctor or facility that renders the service, but is limited by what a reasonable person would consider prompt to be. The requirement of prompt payment means there must be a payment of the discounted amount, which means the discounted amount must be at least one penny.

As to federal and state workers' compensation insurance billing, no amount can be collected from the patient, and the doctor's only source of payment is from applicable insurance. Therefore, there are no discounts to be given to patients in regard to workers' compensation insurance billing.

ICD-9 – Special note about ICD-9 –

ICD-9 diagnosis codes remain in use for all dates of service prior to and including Sept. 30, 2015. There is a popular false belief that ICD-9 is supposedly obsolete, but it is not, and as just stated ICD-9 must be used for all dates of service prior to and including Sept. 30, 2015. In California, the statute of limitations for written contracts is four years, which means that unless shortened by other law (such as Medicare) or contract, providers will be able to bill dates of service prior to and including September 30, 2015 up to four years later. For example, unless shortened by other law or contract, a doctor can bill for services rendered on Sept. 18, 2015 until Sept. 18, 2019. Medicare is the most obvious example of other law that shortens the time period to bill for chiropractic services, which are generally required to be billed within ONE year from the date of service. Contracts with a doctor and an insurance company or other entity can also reduce the time allowed for billing, and many such contracts limit the time to one year following the given date of service. **With personal injury in regard to billing first party medical payments coverage of automobile insurance, the contract between the insurance company and the insured can also limit the time period for both the dates of service rendered eligible for payment as well as the total length of time after the date of service for submission of bills.** Therefore, **do not discard information pertaining to ICD-9, since it potentially can be used until Sept. 30, 2019**.

As far as ICD-10 is concerned, from a technical standpoint ICD-10 only applies to "covered entities" as explained in the following ICD-10 information. Realistically, the vast majority of doctors offices are "covered entities" and the effect is likely to be that many if not most insurance companies are likely to insist on ICD-10 being used in order for payment to be made (because consistency makes their business more efficient) for dates of service Oct. 1, 2015 and thereafter. Therefore, it is likely that ICD-10 will become universal for dates of service Oct. 1, 2015 and thereafter.

ICD-10 -

Overview -

The ICD-10 diagnosis codes have been implemented and are now in force and apply only for Oct. 1, 2015 and thereafter dates of service. ICD-11 is already is already being designed and is projected for implementation in the United States in the 2020s (as of the time of this writing).

Do not mix ICD-9 dates of service and/or codes with ICD-10 dates of service and/or codes on the same billing sheet. Instead, use ICD-9 diagnosis codes with dates of service prior to and including Sept. 30, 2015 on a given billing sheet, and use ICD-10 diagnosis codes with dates of service Oct. 1, 2015 and thereafter on a different billing sheet. Mixing the information inappropriately will result in rejection of the claim.

All of the diagnosis codes for each of these ICD series pertain only to diagnoses, and do not pertain to procedures. A great website to learn about continuously updated issues concerning ICD-10 is www.icd10monitor.com, and another is that of the world health organization (WHO) at www.who.int. Some but not all of the ICD-9 codes covert easily to ICD-10 codes, and some do not. Conversion information is available from a number of sources. A thorough understanding of ICD-10 for most people will involve attendance at a seminar dedicating a significant amount of time to the subject, as many people learn new material easier at an in person seminar. An ICD-10 code book will probably need to be purchased by most doctors. This online course in part provides a clear, concise overview of the subject, but obviously does not provide the benefits of learning in the presence of a teacher.

Legal Authority -

Our United States Congress is the entity that writes the laws pertaining to the ICD diagnosis series, and it is Congress that can change written laws at any time. Congress' proposed laws become the law of the land once our President signs Congress' proposed laws. The law concerning ICD-10 is an addition to existing laws pertaining to federal HIPAA confidentiality. Congress did change the written law which would have implemented ICD-10 as of Oct. 1, 2014, and it was our United States President that signed Congress' proposed law which made it a reality. ICD-10 codes could not be used prior to its implementation, which occurred on Oct. 1, 2015. Any bills submitted with ICD-10 diagnosis codes prior to implementation resulted in rejection of those bills.

To Whom Will/Does ICD-10 Apply? -

ICD-10 laws are part of Federal HIPAA laws, which pertain only to "covered entities," which is the legal term for those doctors who bill electronically, hire a billing firm that files bills electronically, obtain patient health information by computer, send facsimiles (faxes) by computer, or who has a contract with an insurance company that requires the doctor to be HIPAA compliant.

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. This is federal law, and is applicable in addition to state confidentiality laws only if a health care provider, facility, health plan, or billing agency is a "covered entity." Covered entities are those health care providers, facilities, health plans, and billing agencies that transmit health care information electronically, those that use such an electronic transmitter, those contracted to provide private healthcare information electronically, those that obtain patient health information by computer, those that send facsimiles (faxes) by computer, and all doctors who are in states with state laws that mandate HIPAA compliance. Electronically generally means that patient health information is being transmitted by use of computers. This includes accessing websites to verify patient eligibility, sending bills by computer, receiving explanations of benefits by computer, etc. There are two types of fax (facsimile) machines - computer and conventional telephone. Faxing from a conventional telephonic fax machine does not constitute a HIPAA electronic transaction, but doing so via use of a computer does.

Determining whether you are or are not subject to HIPAA laws is discussed elsewhere. If you do not care to be subject to HIPAA laws, simply mail your bills by regular United States Postal Service 1st class mail, do not bill electronically, do not use a billing service that bills electronically, do not enter into any contracts requiring you to bill

electronically or be HIPAA compliant, do not obtain or transmit any patient healthcare information by computer, and do not practice in a state that requires HIPAA compliance. At this point in time, California does not require HIPAA compliance for doctors of chiropractic.

As far as ICD-10 is concerned, from a technical standpoint ICD-10 only applies to "covered entities." Realistically, the vast majority of doctors offices are "covered entities" and the effect is likely to be that many if not most insurance companies are likely to insist on ICD-10 being used in order for payment to be made (because consistency makes their business more efficient). Therefore, it is likely that ICD-10 will become universal for dates of service Oct. 1, 2015 and thereafter.

Personal Injury - There is confusion occurring as to payment of personal injury claims with the use of both ICD-9 and ICD-10 being used for appropriate dates of service. Many insurance companies are choosing their own method of operation in regard to both ICD-9 and ICD-10, despite a number wrongly doing so. Even though "covered entities" (doctors and billing services hired by doctors any of which bill electronically) are required to use ICD-10 diagnosis codes when billing for dates of service Oct. 1, 2015 and forward, a number of automobile insurance companies are wrongfully setting their own policy in regard to the use of ICD-9 and ICD-10 in defiance of the new federal law. For example, at the time ICD-10 was implemented, State Farm processed insurance claims with both ICD-9 and ICD-10, and for an indefinite period of time as to ICD-9 claims regardless of the date of service. In contrast, Progressive Ins. Co. rejects claims for dates of service Oct. 1, 2015 and thereafter using ICD-9. Even though it might be easier to call the given claims adjuster and ask what they will accept, the correct procedure for "covered entities" is to use ICD-10 for claims with dates of service Oct. 1, 2015 and thereafter, and to use ICD-9 with claims of service Sept. 30, 2015 and prior to that date. Doctors who are not "covered entities" (most of those doctors who do not bill electronically) are not required to use ICD-10 by federal law because the mandatory use of ICD-10 for "covered entities" has been added as an attachment to federal HIPAA law. However, doctors who are not "covered entities" are a minority and will probably discover that insurance companies eventually will insist upon all doctors using ICD-10 for dates of service Oct. 1, 2015 and thereafter in order to be paid.

When an insurance company including automobile insurers wrongfully insists upon the "covered entity" doctor using ICD-9 and/or ICD-10 incorrectly (in conjunction with the given date of service), the doctor should keep in mind that doing so would be illegal. Doctors like anyone else as well as business entities must abide by all laws. Using ICD-9 and/or ICD-10 incorrectly in regard to dates of service would be illegal as to "covered entities." Federal laws become the law of the land when the president of the United States signs a bill authored by Congress. Congress' most powerful ability to make laws is based on the Commerce Clause of the United States Constitution. No person or any business entity can interfere with any law. Even though ICD-10 and HIPAA law pertain only to "covered entities," automobile insurance companies cannot rightfully insist in operating in violation of any law, and cannot force others to violate laws. "Covered entity" doctors should only use ICD-9 and ICD-10 properly with claims. If an insurance company does not pay bills, the solution is for the patient to sue the insurance company for breach of contract. In California small claims court, assignees (third party beneficiaries such as doctors) are not allowed to file a claim. Therefore, it is the patient who must file suit against the insurance company.

Specificity -

ICD-10 has approximately 70,000 different codes, which is much more than the approximately 13,000 codes used in ICD-9. The reason for so many greater codes is the desire to be as specific as possible when making diagnoses. ICD-10 is much more specific than ICD-9. For example, there are different diagnosis codes for left side, right side, and an unspecified side. In case you were thinking, there is no code in this system for both left and right sides together, but instead two separate codes must be used for this purpose.

The following details the basic information pertaining to ICD-10. Each ICD-10 diagnosis code contains anywhere from three to seven characters. Some of these characters are numbers, and some are letters. All required code characters must be used when appropriate. Failure to use all required characters in a given codes results in that mistaken code being invalid.

1st Position Character -

The first character in ICD-10 is always a letter, and is specific to one of 21 different chapters within the ICD-10 system. Each chapter uses a particular letter. Most of the chapters are inapplicable to chiropractic, and for that matter most of the codes used by chiropractors belong to just three chapters. In alphabetical order, the letter G is used for the chapter dealing with nervous system diagnoses, M is used for the chapter dealing with musculoskeletal and connective tissue diagnoses, and S is used for the chapter dealing with diagnoses pertaining to injuries and external causes. Diagnoses within other chapters can be and are appropriate for use by chiropractors.

5th & 6th Position X Characters -

The X in each of the fifth and sixth positions functions as placeholders for future designated use, and must be used when required for a code to be valid. X can appear elsewhere in ICD-10 codes, but are usually found in the 5th and 6th character positions. It is possible for the 5th and 6th character positions to have different letters or numbers (such as to define laterality) which designate different meanings.

Laterality -

Laterality is the designation of either the left side of the body or the right side of the body. ICD-10 codes must have this specification when appropriate. When a given diagnosis is appropriate for both the left and right sides of the body, two separate diagnosis codes must be used. The only difference between the ICD-10 designation of laterality is the use of the number 1 (right side) or the number 2 (left side). The use of either of these numbers appears in either the 5th or 6th character position. Examples are M77.31 for calcaneal spur, right side, and M77.32 for calcaneal spur, left side.

7th Position A, D, and S characters -

When there is a 7th position character in an ICD-10 code, it will be either the letter A, D, or S. The letter A means either a) an initial visit or b) any visit with treatment rendered to the patient. The letter D means consultation only, meaning a visit with no treatment rendered. The letter S means the diagnosis pertains to a sequela of an injury, which is a situation where the patient has at least one symptom caused by an injury where the intensity of the symptom has plateaued. For a symptom to plateau, it must have lessened in intensity after the time when injured and where the symptom is still apparent and to a level of intensity as good as can be obtained. A symptom classified as a sequela is different from one classified as chronic. Chronic means a given symptom is present longer in time than the acute and sub-acute stages of healing, but is still improving and is prior to having plateaued.

Chronic and Sequela symptoms simultaneously -

When both chronic and sequela symptoms are present list the chronic diagnoses before the diagnoses pertaining to the sequelae. This isolated view of listing diagnoses is part of the larger hierarchy of listing diagnoses in four general tiers - first listed are traumatic diagnoses, secondly listed are neurological diagnoses, thirdly listed are all symptoms other than neurological diagnoses previously listed, and lastly are diagnoses pertaining to underlying conditions.

Conversion from ICD-9 to ICD-10 -

Conversion of a diagnosis from ICD-9 to ICD-10 is not necessarily straightforward. ICD-10 codes must be as specific as possible within that system and are not necessarily routine. There are numerous sources that will assist in the conversion of an ICD-9 diagnosis code to that of ICD-10, but one must use caution. The reasons for caution are that the doctor will always need to be consciously thinking of the proper conversion so as to be as specific as possible, and conversions given by various websites and books are not necessarily as specific as possible. A detailed ICD-10 code book will probably be a must have item. A variety of websites provide information and tools to convert ICD-9 codes to ICD-10 codes, and vary in price from free to expensive. Free websites include www.icd9data.com and www.icd10data.com.

Example -

An example of an ICD-10 diagnosis code is S13.4XXA (cervical sprain with treatment). There are several things to notice in this example. Firstly, there are seven characters, with the first, fifth, sixth, and seventh being letters, and the others being numbers. This is the pattern for ICD-10 codes. Next, the first letter S designates a diagnosis from the chapter pertaining to injuries and external causes. The X in each of the fifth and sixth positions functions as placeholders for future designated use, and must be used when required for a code to be valid. The letter A in the last position means that this diagnosis pertains to either a) an initial visit or b) any visit with treatment rendered to the patient.

5 + 1 Defined Areas of the Body for Billing Purposes -

For billing purposes in reference to procedure codes, there are five expressly defined areas of the human body. Everywhere else not defined in those five areas can be considered to be an implied sixth defined area. The five defined areas of the body are as follows:

1) cervical + atlanto-occipital joints
2) thoracic + all rib joints
3) lumbar
4) sacrum, and
5) iliae (implied from the pelvis minus the expressly defined sacral area).

By implication, the sixth defined body area is everywhere not previously defined. This means that the sixth area is all extremity joints other than the atlanto-occipital and rib joints.

Adjusting an occiput at the atlanto-occipital joint is included in the first defined area of cervical plus the atlanto-occipital joints. Likewise, adjusting any rib whether it be on the anterior and/or posterior of the patient body is included as part of the second defined area of thoracic plus all rib joints. However, adjusting a cranial fault would be an extremity adjustment since it is not included in any of the five expressly defined areas.

The proper CPT code to bill for any of the expressly defined areas depends on how many of those areas were adjusted on a given day as follows:

98940 - adjustments were made in 1-2 defined areas
98941 - adjustments were made in 3-4 defined areas
98942 - adjustments were made in 5 defined areas

The proper CPT code to bill for any extremity adjustment(s) NOT included in the five expressly defined body areas is 98943 (other than the atlantooccipital joints and ribs).

It is permissible to bill the CPT code 98943 when an extremity in one of the five defined areas has been adjusted in addition to an extremity not included in any of the five defined areas. For example, on a given day when a patient has had a rib and a clavicle adjusted, it is permissible to bill the CPT code of 98943 because the clavicle does not form a joint with any structure contained within the five defined areas.

97140-59 -

The 59 CPT billing modifier is poorly defined and by the book means that the main code to which it is attached is a procedure separate and distinct from another procedure. This modifier realistically means that the physical therapy performed on given parts of the body is separate and distinct from other given parts of the body where adjustments were performed, relative to the five defined areas of the body for billing purposes.

97140-59 is only payable on a given day when the physical therapy performed on a patient is on an area of the body that is different than areas of the body receiving adjustments in the five defined areas for billing purposes. These "areas" are actually those of the 5 defined areas of the body, as just previously described.

Without realizing that the purpose of the -59 modifier is in reference to the five defined body areas, it is frustrating to suffer the consequences of omitting this modifier. The result of an omission is usually non-payment for the 97140 code.

The 97140 CPT billing code includes a variety of soft tissue techniques including trigger point therapy, soft tissue mobilization, manual traction, and others. It is important to document the given body parts where the 97140 physical therapy was performed so as to differentiate that treatment with its areas as compared to the areas that were treated with spinal adjustments.

Non-Payable example -

On a given day, the doctor adjusts the atlas and a left T2 rib at the costovertebral joint, and performs trigger point therapy on the left and right medial trapezius muscles towards the top of the middle back. As a result the trigger point therapy is not payable for that day because it was performed in the same defined body area as the rib adjustment, because both involve the defined area of thoracic vertebrae plus all rib joints. However, the spinal adjustment charge is payable. As another example, trigger point therapy in the suboccipital area is not payable when there has been a cervical or atlantooccipital adjustment on the same day to a given patient.

Payable example -

On a different given day, the doctor adjusts the atlas and performs trigger point therapy on the left and right medial trapezius muscles towards the top of the middle back. As a result the trigger point therapy is payable for that day because it was performed in a different defined body area (thoracic) than where the patient was adjusted. The spinal adjust charge is also payable. It would be wise to clearly document the part of the body where the 97140 physical therapy was performed so as to have proof of the code being payable, and to avoid a legitimate request for a refund of overpayment from an insurance company.

Legitimate Requests for Refunds -

California Board of Chiropractic Examiners Rules and Regulations Article 2, section 318(b) requires a doctor of chiropractic to make full reimbursement of any overbilling within 30 days of either its discovery or notification. Failure to reimburse legitimate amounts due with that 30 time period constitutes unprofessional conduct. The worst possible consequence for unprofessional conduct is revocation of licensure. Legitimate reimbursements are required regardless of whether or not the doctor is otherwise compensated by any other source.

Requests by insurance companies for refunds of overpayment (overbilling) in regard to non-payable 97140-59 payments that were actually made are becoming more common as compared to previous times. Usually the demand is made on the basis there being a failure of adequate documentation to prove that the 97140 physical therapy rendered occurred in a defined area of the body different from that of an adjustment. Assuming that there was a lack of proof of the 97140-59 code being payable, it would be wise to promptly refund a legitimate request for this rather than committing unprofessional conduct (which subjects a doctor to very serious discipline).

Use the Most Appropriate CPT Procedure Code(s) -

It is of extreme importance to use the most appropriate procedure code or codes. Whenever a given procedure is subject to two or more reasonable interpretations, there is ambiguity. Whenever there is no well defined precise procedure code, the ambiguity is resolved based on the doctor's intent. For example, a muscle could be stretched with a variety of different intentions.

Examples of using the most appropriate CPT code are as follows: 97110 would be the appropriate procedure code to use when the muscle is stretched with the intention to increase flexibility, because that code is used for the purpose of therapeutic exercise with the intention to increase strength, flexibility, range of motion, and/or endurance. If the doctor's intention were to improve movement and balance (or one of the two), 97112 would be most appropriate because it is used for neuromuscular reeducation with the intention to increase proprioception, movement, balance, coordination, posture, etc. 97124 would be the most appropriate code to use if the purpose was to merely relax the patient or have them feel good. 97140 would be appropriate if the intention was to perform manual traction or joint mobilization.

Medicare Explained -

Overview -

As part of the Social Security Amendments of 1965, Congress established two new programs to cover the cost of medical care for the elderly and disabled. These two programs have become known as Medicare Part A and Medicare Part B. Medicare Part A covers inpatient hospital and other institutional provider care, none of which has any relevance to chiropractic. The word "inpatient" means that a given patient was admitted for at least an overnight stay in a health care facility. Medicare is administered by the Centers for Medicare and Medicaid Services (CMS), which is a part of the executive branch of the United States federal government. CMS maintains a website that includes Medicare information, and that website is www.cms.gov.

Medicare Part B -

Medicare Part B pertains to outpatient (where the patient is not admitted for an overnight stay) health care, and is relevant to chiropractic care. This program is financed through monthly premiums from enrollees (Medicare beneficiaries) as well as contributions from the federal government. Medicare beneficiaries are issued a paper card with their name and Medicare number on it, and there is a red, white, and blue stripe across the top of the card. The doctor of chiropractic should copy the patient's Medicare card and include it in their file of that patient. Medicare Part B pays doctors of chiropractic who are enrolled with Medicare 80% of what they allow for spinal adjustments (which Medicare refers to as manual manipulation), with the patient being responsible for the other 20%, and only after the patient's calendar year deductible has been met. However, Medicare will not pay enrolled doctors of chiropractic who are NOT contracted with ASHP when adjusting the spine of a Medicare beneficiary who also have HMO insurance. Anything other than spinal adjustments (e.g. exams, radiology, physical therapy, etc.) will not be paid by Medicare to doctors of chiropractic. The amount of the deductible has been changed from time to time, and so has the number of visits allowed as payable each year. At the time of this writing, there is no limit on the number of payable spinal adjustments based on medical necessity being proven.

Enrollment in Medicare Part B by Doctors -

Each doctor of chiropractic has the choice of whether or not to be enrolled as a provider of services in Medicare Part B. There is a huge amount of information to be furnished with the initial application to become enrolled with Medicare Part B, and much of this voluminous amount of information is also required to be updated with the recredentialing process. It is a good idea to keep a copy of the application forms submitted. With the original application, there is the opportunity to choose whether to be either a participating or non-participating provider of services. The designation obligates the doctor to have the same participating or non-participating classification for the remainder of the calendar year. The doctor has the opportunity toward the end of every calendar year (during the Open Enrollment Period from Nov. 14 – Dec. 31 with Noridian Medicare) to change their classification as to either participating or non-participating for the forthcoming calendar year, and the change can only occur with a timely submitted signed writing to Medicare toward the end of any given year. A doctor's classification for participating or non-participating will remain the same for each forthcoming calendar year unless timely changed.

Prohibition of Billing by Doctors Not Enrolled in Medicare Part B -

Those doctors who are not enrolled as a provider of services in the Medicare Part B program are absolutely prohibited from submitting billing to Medicare. However and contrary to widely disseminated incorrect information, they are permitted to provide chiropractic services including spinal adjustments to Medicare beneficiaries. Problems occur when a Medicare beneficiary submits proof of their payment for spinal adjustments performed on them by a doctor of chiropractic who is not enrolled in Medicare Part B. The doctor will receive a letter from Medicare's provider services department that often wrongfully states that the doctor is required to enroll as a provider of chiropractic services because they received either billing or a receipt from the patient. The truth is generally that a doctor is only required to enroll as a provider of services in Medicare Part B if they themselves or their office submitted billing for services rendered to a Medicare beneficiary; the key is to be able to provide proof that the patient withheld their permission for the doctor to bill Medicare.

How to Resist Medicare Part B's Attempt to Enroll a Doctor -

A letter to Medicare stating that the doctor is actually not required to be enrolled because neither they nor their office submitted billing to Medicare should be sufficient to put a stop to this. Better yet is proof that the patient acknowledged by their signed writing that the doctor is prohibited by law from billing Medicare due to not being enrolled in the program, and that the patient withholds their permission for the doctor to bill Medicare. This signed writing can be and usually is the doctor's own form with the patient's signature, and CANNOT be on CMS's Advanced Beneficiary Notice (ABN) form (due to only Medicare enrolled doctors being able to use that form). Make sure the wording from the most recent version of the ABN form is used, and with option 2 checked as well as including all other required information. It is important to have this written proof because a certain percentage of Medicare beneficiaries tend to lose their memory later in life. Also, the vast majority of elderly people are dependent upon social security benefits, and tend to have a shortage of available money. The result is that sometimes Medicare beneficiaries submit their receipts for what they have paid for health care in an attempt to get whatever money they can get from Medicare. Having a properly signed form similar to the ABN form is the proof needed for this purpose. If you have any questions about this, call the author.

Advance Beneficiary Notice of Non-Coverage (ABN) Form -

The ABN form is Medicare's form to be used only by enrolled doctors, and is required (other than with certain exceptions) when generally payable services are not expected to be paid by Medicare, Active Therapy ends, and when maintenance therapy begins. This form is not required to be used when payments will never be issued by Medicare (such as with exams, x-rays, and physical therapy performed by chiropractors), although it may optionally be used. The most recent version of the form must be used, which is CMS-R-131. At the time of this writing the most recent form is the version that states “Form CMS-R-131 (Exp. 03/2020)” at the bottom left of that form. This form is not required in emergency or urgent situations. Boxes D, E, and F must be completed on the top 1/3 of the form. The ABN form can only be used when a Medicare beneficiary is being treated by a doctor enrolled with Medicare. This form is prohibited from being used when the doctor is not enrolled with Medicare. However, nothing prevents a non-enrolled doctor from using the same wording as part of their own form as long as it is not the ABN form itself.

The letter A at the top of this form is completed with the name of the notifier, which is the doctor or their office. Letter B is completed by listing the patient's name. Letter C is completed by listing the patient's identification number. The best identification number to be used for a Medicare beneficiary is the patient's Medicare number, since that number will be recognized by Medicare. Box D is completed with the services to be rendered by the chiropractor, and these services can be listed by CPT code and/or verbal description. Box E is completed with the reason or reasons Medicare may not be expected to pay. Box F is completed by listing the estimated cost for each service. The patient must read the form, and then the form must be explained to the patient, and the patient must be given the opportunity and ask any questions they have pertaining to the form. One of the three options toward the middle of the form must be checked after the patient reads and asks any questions about the form. Box G provides three options, of which only one is checked. Option 1 is used when the patient wants the services listed in Box D as well as assurance of Medicare being billed, their right to a Medicare appeal, and written confirmation of appropriate refunds being made by the doctor to the patient. Option 2 is checked when the patient wants the services listed in Box D and instructs the doctor (or their office) not to bill

Medicare. Option 3 is checked when the patient wants written proof of not wanting services listed in Box D. Letter H provides a small amount of space to put additional information, if any. The patient then signs and dates the form in Boxes I and J, respectively.

The ABN form is valid for 365 days (not a calendar year) from when it is signed. A new and similar form will be needed prior to the first adjustment after the 365 day time period is expired, when one of the three options in Box G applies. The patient is then given a copy of their signed and dated form, and the doctor keeps the .original in their chart of the patient.

References concerning the ABN form include the Medicare Claims Processing Manual, Publication 100-4, Chapter 30, §50 as well as www.cms.gov/bni. Both of these references are found on the internet.

Participating versus Non-Participating Classification -

There are only two benefits but a significant detriment for being classified as a participating provider of chiropractic services in the Medicare Part B program. The benefits are that a participating doctor of chiropractic is paid by Medicare approximately 5 percent more for spinal adjustments as compared to a non-participating classification, and the check is made payable to the doctor and mailed to the doctor. However, the amount approved by Medicare for participating providers (for only spinal adjustments) is still approximately 9% less than the amount able to be collected with a non-participating enrolled provider who for whatever reason chooses not to accept assignment for spinal adjustments. The huge detriment is that a participating doctor foregoes any other insurance payments available by insurance companies other than Medicare Part B when first billing Medicare Part B is required by the other insurance. A Medicare enrolled doctor can choose once per year toward the end of the year during the Open Enrollment Period (Noridian for northern California has this time period from Nov. 14 – Dec. 31) to change their status from participating to non-participating or vice-versa by submitting a signed writing to Medicare.

Significance of the Participating Classification -

The designation of being a participating doctor in the Medicare Part B program has the obligation of the doctor ALWAYS accepting assignment, which is indicated by checking the yes box in block 27 of the CMS-1500 billing form. Accepting assignment means that the doctor will accept as payment in full the amount allowed by Medicare, even for charges other than for spinal adjustments, even when Medicare approves zero to be paid, and even when there is other insurance available in addition to Medicare Part B, when billing is first submitted to Medicare. Accepting assignment also results in Medicare's payment being in the name of the doctor and being sent to the doctor.

Since Medicare Part B pays chiropractors only for spinal adjustments, the amount allowed for services rendered by doctors of chiropractic other than for spinal adjustments will be zero. Medicare will always allow zero for examinations, radiology, physical therapies, etc. performed by doctors of chiropractic or their offices. Sometimes patients have health care insurance benefits available from policies other than Medicare Part B that will potentially pay doctors of chiropractic. However, if these policies require Medicare to be billed first (making them excess policies, whether the policy is either secondary or supplemental), the result is that the excess insurance policy will pay a participating doctor of chiropractic zero due to the Medicare Part B requirement of always accepting assignment, which means that the participating doctor agrees to accept Medicare's allowed amount of zero as being payment in full. This situation also relieves the patient of liability of those services to the doctor, which means the patient does not owe the doctor anything for billing submitted with these circumstances where Medicare allows zero.

For purposes of clarification, an enrolled doctor with a participating classification will be paid more by Medicare for spinal adjustments than paid to non-participating doctors, and can still be paid from additional insurance benefits for services other than spinal adjustments provided Medicare is not required to first be billed, and Medicare is actually not billed for non-spinal adjustments. This comment requires an explanation of excess insurance, which includes both secondary and supplemental insurance policies.

Excess, Secondary, and Supplemental Insurance -

Excess insurance is insurance that pays only after all other insurance has been billed and acted upon, with the proof (being the explanations of benefits (EOBs)) submitted to the excess insurance company. Some excess insurance is secondary, while other excess insurance is supplemental. Secondary insurance is insurance that pays its defined benefits regardless of what the previously billed, other insurance pays. In contrast, supplemental insurance pays only for their portion of the benefits approved by the previous insurance. This situation typically occurs with Medicare (and only when a Medicare beneficiary does not have HMO insurance) when a Medicare beneficiary buys insurance in addition to that of Medicare.

Approximately 95% of Medicare beneficiaries are on fixed income, and health care benefits are of extreme concern. At the time of this writing, Medicare pays for 80% of the approved amount of an unlimited number of chiropractic spinal adjustments (which they call manipulations) provided there is an acute condition likely to be helped with chiropractic, and once the patient has first met their calendar year deductible. Many senior citizens/Medicare beneficiaries are very concerned with paying for the other 20% of Medicare's allowed amount, and thus they purchase excess insurance (either secondary or supplemental).

Medicare only pays chiropractors for spinal adjustments, and not for anything else. Secondary (to Medicare) insurance pays not only the 20% of the amount allowed by Medicare for spinal adjustments, but also pays for itemized billing for most other charges, such as exams, x-rays, and physical therapy. However, supplemental (to Medicare) insurance pays only the deductible and the 20% not paid by Medicare for spinal adjustments only.

With personal injury, Medical Payments (Med Pay) coverage is usually primary, but sometimes is excess. When Med Pay is excess, all other insurance policies must be billed and the corresponding EOBs obtained with copies sent to the Med Pay auto claims adjustor. All other insurance policies includes even those insurance companies that don't pay chiropractic benefits, or those that won't pay chiropractic benefits to a given chiropractor (which is usually a contract issue, such as not being a provider in a given organization), including but not limited to Medicare. For clarity, don't forget that doctors of chiropractic who are not enrolled in the Medicare system are absolutely prohibited from billing Medicare, and to do so would be illegal. Therefore, when there is an excess medical payments insurance policy available when treating a Medicare beneficiary, a doctor of chiropractic who is not enrolled in Medicare is still absolutely prohibited from billing Medicare, and should also be relieved of that requirement in order to receive payment from the excess medical payments insurance company.

It is wise to call a patient's insurance companies and determine not only the standard limitations (deductibles, number of visits or dollar amount per year, etc.), but also whether the policy is an excess policy, and if excess whether it is secondary or supplemental.

Significance of the Non-Participating Classification -

The greatest significance of a doctor of chiropractic who is enrolled in the Medicare Part B program as a non-participating provider of chiropractic services is that they are able to choose whether or not to accept assignment on EACH INDIVIDUAL BILLING FORM submitted. Although a non-participating enrolled doctor has this option, an enrolled but participating doctor does not. The effect of making an ideal choice on each individual billing form is the maximization of payment by insurance companies. Only enrolled providers with a non-participating classification can make this choice, which is done on each individual billing form.

The ideal strategy is to have a given billing form with ONLY spinal adjustment procedure codes with box 27 marked as yes (so as to accept assignment), and have all other procedure codes billed on separate billing forms with box 27 marked as no (so as to not accept assignment). The reason for this strategy is that accepting assignment means that the doctor is accepting Medicare's determination of the amount payable as the most that can be collected by the doctor. Additionally, the maximum that can be collected for services rendered is the limiting charge set by Medicare, but only pertains to spinal adjustments for doctors of chiropractic. Also, Medicare payment is made in the name of the doctor and mailed to the doctor when assignment is accepted. When assignment is not accepted, the check for payment if any is

made in the patient's name and mailed to the patient. Therefore, the doctor remains eligible to be paid insurance benefits from insurance companies other than Medicare for procedures other than spinal adjustments only when not accepting assignment when Medicare must first be billed as required by an excess insurance policy.

When box 27 on the billing form is left blank with no indication of whether the doctor is accepting assignment or not, Medicare construes an interpretation of the doctor having chosen to accept assignment. All of the consequences (good and bad) of doing so will follow.

Although an enrolled non-participating doctor receives a Medicare payment about 5% less than an enrolled participating doctor for spinal adjustments, they are able to ultimately collect about 9% more than a non-participating doctor.

Medicare Part B Billing Limitations

Actual Charge Restrictions -

The Medicare program has several rules that limit how much Medicare beneficiaries can be charged, called actual charge restrictions. The purpose of these actual charge restrictions is primarily to protect Medicare beneficiaries from excessive charges by Medicare enrolled providers and suppliers. These particular actual charge restrictions apply to Medicare providers and suppliers who do NOT accept assignment (also known as non-participating enrolled Medicare providers and suppliers, a.k.a. non-par enrolled Medicare providers and suppliers). In contrast, Medicare enrolled providers who accept assignment are restricted by separate rules.

Limiting charge concept -

The key actual charge restriction is the "limiting charge," which sets a maximum amount as to how much a Medicare enrolled provider or supplier may charge (and therefore accept) in excess of the Medicare payment amount for any given Medicare approved fee for service. The limiting fees apply only to various procedure codes that Medicare approves for payment (fee for service) for any given license/type of health care/provider. For example, Medicare only approves procedure codes 98940, 98941, and 98942 for payment to doctors of chiropractic. Therefore, doctors of chiropractic who are enrolled as providers with Medicare are only restricted as to what they can charge and collect for services rendered to a Medicare beneficiary as to spinal adjustments, but are not limited for any other services rendered (such as exams, radiology, physical therapy, etc.).

Limiting charge defined -

The limiting charge is specific for any given county, and is 115% of the fee schedule amount for non-participating Medicare enrolled providers and suppliers [Soc. Sec. Act §1848(g)(2)(C); *Medicare Claims Processing Manual*, Pub. 100-04, Ch. 1, §30.3.12.3]. The fee schedule amount for non-participating Medicare enrolled providers and suppliers is 95% of the listed fee schedule amount for each fee for service [Soc. Sec. Act §1848(a)(3)]. Therefore, the limiting charge is 115% of 95% of the listed fee schedule amount for each fee for service. The limiting charge with other information is published as a yearly revised Medicare Part B Fee Schedule, which is required to be and actually is published on each Medicare carrier's website [*Medicare Claims Processing Manual*, Pub. 100-04, Ch. 1, §30.3.12.1.B2]. For Northern California, this information is published on the Noridian website, which is www.nordianmedicare.com. Another excellent source for limiting charges over a number of years is www.cms.gov. Make sure you view the proper information for the county where services were rendered to the Medicare beneficiary.

Limiting charge applications -

Limiting charges apply to Medicare enrolled providers and suppliers. The Medicare fee schedule applies only to D.C.s enrolled with Medicare and only to spinal adjustments. Providers are broadly construed in reference to Medicare, and include physicians (which has a broad definition for Medicare purposes and includes many types of health care providers, not merely those who are licensed to prescribe medications), doctors of chiropractic, physical therapists,

occupational therapists, ambulance services, hospitals, and others. Medicare enrolled providers and suppliers are not allowed to bill or collect from Medicare beneficiaries amounts over the limiting charge for services Medicare can potentially pay a given provider based on the given type of provider/supplier (i.e. doctors of chiropractic, medical doctors, physical therapists, ambulance services, hospital, etc.) [Soc. Sec. Act §1848(g)(1)(A)]. A Medicare provider who charges a patient more than the limiting charge must refund the difference when an amount has been collected over the limiting charge. A corrected billing must be submitted if there was an incorrect billing initially made [Soc. Sec. Act §1848(g)(1)(A)(iv)]. The most a Medicare enrolled doctor of chiropractor can collect for spinal adjustments (98940, 98941, and 98942) performed on a Medicare beneficiary is the lesser of their general fee schedule and Medicare's limiting charge.

Mandatory claims submission -

Medicare enrolled providers and suppliers are required to bill Medicare Part B for medical services (broadly defined), equipment, and supplies rendered to a Medicare beneficiary within 12 months of the date of service [Soc. Sec. Act. §1848(g)(4), *Medicare Claims Processing Manual*, Pub. 100-04, Ch. 1, §§70.8.6, 70.8.8], UNLESS the patient has signed a writing prohibiting the doctor from billing Medicare such as Medicare's ABN form (with option 2 checked). This mandatory claims submission requirement for enrolled doctors of chiropractic pertains only to spinal adjustments. Medicare enrolled providers and suppliers are prohibited from charging a patient any fee for completing and/or submitting claims, and those providers and suppliers who fail to either submit a claim or who impose charges for completing claims are subject to Medicare sanctions [Soc. Sec. Act. §1848(g)(4), *Medicare Claims Processing Manual*, Pub. 100-04, Ch. 1, §70.8.8.6]. However, doctors who are NOT enrolled with Medicare are absolutely PROHIBITED from billing Medicare.

Medicare Pays only for Active Therapy -

Medicare pays only for active therapy (AT), which for doctors of chiropractic is the rendering of spinal adjustments expected to provide recovery or improvement of function to correct a subluxation causing a neuromusculoskeletal condition for which manual manipulation is appropriate. Said in another way, Medicare pays only for what it deems medically necessary for spinal adjustments where this care is expected to reduce a patient's symptoms (especially pain), which is active therapy. Medicare does not pay for anything other than active therapy, such as maintenance care. Medicare's definition of maintenance care includes three situations - 1) where further clinical improvement is not expected, which is supportive and not corrective, 2) where the treatment plan seeks to prevent disease, promote health, and prolong and enhance the quality of life, and 3) where treatment is performed to maintain or prevent deterioration of a chronic condition. Keep in mind that Medicare's definition of the word "chronic" is different from that used in reference to ICD-10. Medicare's definition of "chronic" is focused on a longstanding condition where there is no reasonable expectation of clinical improvement.

Medicare pays D.C.s for spinal adjustments only based on active therapy expected to improve at least one symptom with chiropractic AND where active therapy is clearly shown on the appropriate billing form. Stated in another way, Medicare will pay 80% of their allowed amount for spinal adjustments after the patient's calendar year deductible has been met, provided the care is for an acute condition expected to be helped with chiropractic, when appropriately shown on a billing form with the modifier "AT." The correct way to indicate that a spinal adjustment was performed as part of active therapy is to use the modifier "AT" under the modifier section in box 24D of the current version of the CMS-1500 billing form. Box 24D's right hand portion is used for modifiers, and has space for four modifiers. Only appropriate modifiers should be used. In other words, only list the necessary and appropriate modifiers for a given procedure code. All four spaces for modifiers do not have to be used when not necessary. For spinal adjustment codes (98940, 98941, and 98942), Medicare will only pay when the AT modifier is listed to the right of the spinal adjustment procedure code in box 24D. Inadvertently not listing the AT modifier results in non-payment for the spinal adjustment on the basis of Medicare interpreting the adjustment as being rendered for a purpose other than for active therapy.

Medicare ICD-10 Diagnosis Codes –

For dates of service Oct. 1, 2015 and thereafter, the only thing that has changed in reference to billing is the required use of ICD-10 codes. Just as with ICD-9, Medicare requires a primary diagnosis code and a secondary diagnosis

code for each defined (cervical, thoracic, lumbar, sacrum, and pelvis) area with diagnoses. For dates of service Oct. 1, 2015 and thereafter, the primary diagnosis codes can only be from the following:

ICD-10 Primary Codes –

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

One appropriate secondary code must then be selected to be used in conjunction with each primary diagnosis code. These secondary codes are to be chosen from one of three categories – category one indicates expected short term treatment, category two indicates expected moderate term treatment, and category three indicates expected long term treatment. It would be wise to perform sufficient testing and documentation especially when there is expected long term treatment to be rendered so as to avoid problems if ever audited by Medicare. The list for the choices for secondary codes is too long to be detailed here, and this long list is available along with other ICD-10 help on the CMS website at www.cms.gov/icd10. This web address has a variety of helpful tools to assist doctors' offices with the proper use of ICD-10.

Medicare Billing Modifiers -

The following is a list of commonly used Medicare billing modifiers used by doctors of chiropractic:

AT	Active Therapy as defined and previously discussed
GA	signed ABN form is on file; used only with spinal adjustment codes
GX	signed ABN form is on file; may be used with GY; do not use with GA with spinal adjustments CPT codes as the result is non-payment
GY	statutory denial of Medicare payment; used with non-spinal adjustment CPT codes; do not use with GA as the result is non-payment
GZ	ABN is NOT on file, with the result of no financial liability to the patient
GP	non-spinal adjustment physiotherapies

Examples of the use of these modifiers with Medicare billing are as follows:

99203	GY 25 (the 25 modifier means that evaluation and management of a patient was performed over that required for the spinal adjustment)
98941	AT
72040	GY
97012	GY GP

As demonstrated above, multiple modifiers can be used simultaneously when appropriate. Additionally, there can be a mixture of modifiers specific to Medicare with generally applicable modifiers.

Physician Quality Reporting System (PQRS) -

The Physician Quality Reporting System (PQRS) is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs) and group practices. The program provides an incentive payment to practices with eligible professionals (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]) who successfully report clinical quality data for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer).

Section 1848(a)(8) of the Social Security Act, requires the Centers for Medicare & Medicaid Services (CMS) to subject EPs and group practices who do not report data on PQRS quality measures to a payment adjustments. Eligible professionals and group practices receiving a PQRS payment adjustment in 2016 were paid 2.0% less than the PFS amount for services rendered January 1-December 31, 2016 (or received 98% of his/her allowed Medicare Part B PFS amount for covered professional services that would otherwise apply to such services). The reporting period for the 2016 PQRS payment adjustment was the 2014 program year.

Individual eligible professionals (regardless of participation in other CMS incentive programs) **avoided** the 2016 PQRS payment adjustment if ***at least one*** of the payment adjustment criteria was met during the 2014 PQRS program year of **January 1-December 31, 2014**.

The Physician Quality Reporting System (PQRS) is Medicare voluntary paper review system. Medicare has taken the perspective of managed care to a limited degree by encouraging enrolled providers to prove the need for care. Use of its methods also qualifies for electronic health records requirements. Use of the appropriate modifiers used by PQRS qualifies providers for bonuses provided the enrolled provider timely complied within the initial reporting period.

An approximation of the amount to be deducted for each adjustment to a Medicare beneficiary where the doctor has not complied with PQRS requirements is 50 cents. For a doctor of chiropractic who bills Medicare a total of just 10 spinal adjustments for all Medicare beneficiaries seen in a calendar year, the reduction would be approximately $5.00 total. Only if the doctor treats many Medicare beneficiaries would compliance with the PQRS program be worth the while for the doctor. It is an individual doctor's decision whether or not to learn and comply with a new system.

Pain is reported by most doctors in their chart notes using a zero to ten scale, with zero being no pain and ten being the maximum possible pain. Other doctors use a zero to four scale. The following codes are used for reporting pain and are listed on billing forms just like CPT codes:

G8730 - used each day a patient is treated with reported pain, a pain scale is reported, and treatment is continuing
G8731 - used when there is no pain and no further corrective treatment is scheduled

Functional assessment reporting involves either the Oswestry (for low back) or Neck Disability Index on initial examinations as well as reexaminations. Reexaminations are expected to be conducted within 30 days of the previous exam. The following codes are used for reporting functional assessment and are listed on billing forms just like CPT codes:

G8539 - used for dates of service when a functional assess outcome test has actually been performed, but not greater than 30 days
G8942 - used when the functional assessment outcome test is not performed on a given date of service BUT is on file as having been performed in the last 30 days
G8542 - used when the functional assessment outcome is negative and the patient is placed on maintenance care or is released

There is much more detailed information available on this topic on the Centers for Medicare and Medicaid Services website, which is www.cms.gov. The information provided in this section is merely a cursory introduction, and space does not permit a more detailed explanation than what is provided here.

<u>Medicare Subluxation Documentation Requirements</u> -

In order for payment to be authorized, Medicare requires adequate documentation of subluxations in one of two ways. This documentation is satisfied by either plain film x-ray radiographs or by physical examination.

X-ray radiographs are deemed acceptable to Medicare if taken within the time frame of 12 months prior to initial care until three months following initial care. Older (than 12 months) plain film x-ray radiographs can be used for documentation provided they show applicable permanent conditions (e.g. degenerative joint disease).

The physical exam can also be used to adequately document subluxations for Medicare purposes. There needs to be documentation of at least one subluxation for each area of the spine given a diagnosis. Subluxations need to be documented using the acronym P.A.R.T., where P stands for pain or tenderness, A stands for asymmetry or misalignment, R stands for range of motion abnormality with decreased segmental range of motion, and T stands for tissue or tone changes in the characteristics of contiguous soft tissues. For pain, make sure to document the location, quality, and intensity of the reported pain.

Initial Visit Documentation -

Medicare requires specified details of a patient initial visit to be documented. These include all standard aspects of a history as taught in chiropractic college, including a description of the present illness (also known as the chief complaint). An adequate physical examination of the musculoskeletal system must be properly documented, including diagnoses the way Medicare wants to see diagnoses.

Dates of service prior to and including Sept. 30, 2015 will no longer result in payment by Medicare (because it has been more than one year since that date), and Medicare required an ICD-9 primary diagnosis of subluxation in the 739 series by a doctor of chiropractic, even when the subluxation(s) was(were) caused by trauma. Keep in mind that 739 series diagnoses of subluxations are non-traumatic by definition. Likewise, 839 series diagnoses of subluxations are traumatic by definition. However, Medicare is not concerned with this important distinction, even when there was a traumatic event such as an automobile accident that caused subluxations in a patient.

When a Medicare beneficiary is treated for subluxations that were caused by a traumatic event, and there is also other insurance available for payment (such as with an automobile accident), billing with the proper diagnosis codes for subluxations will have to be created for each of Medicare and the other insurance. The insurance company other than Medicare will also need an explanation for the simultaneous and conflicting subluxation codes (non-traumatic and traumatic). The explanation to be given to the insurance company other than Medicare is the truth and is as follows: The reason for the conflicting and simultaneous subluxation diagnoses in both the 739 and 839 series is that Medicare requires subluxation diagnoses only in the 739 series, regardless of the cause of the subluxations. Medicare's diagnosis requirements are an isolated system, and disregard the realistic distinction between traumatic and non-traumatic causes of subluxations. Only due to an enrolled Medicare doctor of chiropractic being required to make subluxation diagnoses in a non-traumatic manner to Medicare were the 739 series of subluxations made. The 739 subluxation diagnoses would not have otherwise been made with a traumatic cause of those subluxations, such as with an automobile accident.

For dates of service Oct. 1, 2015 and thereafter, Medicare always requires an ICD-10 primary diagnosis of subluxation in the M99.0x series (M99.00, M99.01, M99.02, M99.03, M99.04, and/or M99.05). The description of the M00.0x series of codes is segmental dysfunction, which mimics the non-traumatic terminology of the ICD-9 series 739 subluxation codes. Similar to what was just described in the preceding paragraph, it is best to list diagnoses in the M99.1x series (subluxation complex – consistent with chiropractic philosophy and no inference of being non-traumatic) when billing insurance other than Medicare along with the explanation just stated in the previous paragraph.

Medicare also requires a secondary diagnosis code which is used not only to be descriptive of the cause of the subluxations, but also to indicate a likely timeframe for the duration of treatment. The secondary diagnosis is the most applicable diagnosis chosen from one of three categories. These diagnoses can be found on the cms.gov website. Always use ICD-9 diagnosis codes for dates of treatment prior to and including Sept. 30, 2015, and ICD-10 diagnosis codes for dates of treatment Oct. 1, 2015 and thereafter.

Additionally, a treatment plan with the frequency and duration of recommended, specific treatment goals, and objective measures to evaluate treatment effectiveness need to be documented, as well as the date of the initial treatment.

Only when billing Medicare, the date the doctor of chiropractic first professionally saw the Medicare beneficiary for their condition is the date stated in box 14 of the proper CMS-1500 billing form. This date could very well be different than the date of onset, used by all insurance other than Medicare.

There is a excellent manual on the cms.gov website that explains a lot of key Medicare information for chiropractors, and it includes numerous references. It is called the Chiropractic Services Booklet, and a search on their website will easily locate it. A lot of information is found in the Medicare Benefit Policy Manual; Chapter 15 Section 240 – Chiropractic Services, which can accessed on the internet at the following web address:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Subsequent Visits Documentation Requirements -

Subsequent visits need to be adequately documented per Medicare standards. As to the history, Medicare requires a review of the chief complaint, changes of the chief complaint since the previous visit, and a review of systems if relevant. As to a physical exam, examination of the diagnosed spinal area, assessment of the change of the patient's condition since the previous visit, and evaluation of treatment effectiveness are required. Documentation of each days' treatment is also required.

Additional Documentation for Pages Other than Bills -

As to any page with documentation other than original billing forms, for most D.C.s Medicare requires either a legible original signature or an electronic signature signed anywhere on the given page. For example, a copy of the pertinent chart notes is a smart idea to include along with the original bills so as to comply with Medicare's documentation requirements. Since the copy of chart notes is not an original billing page, Medicare requires the doctor to sign their original signature anywhere on that page (or those pages) or have an electronic signature on that page. The location of the signature can be anywhere on the page, but should not obscure information.

Medicare allows a stamped (as an alternative to either the original or electronic) signature only if a D.C. has a well documented disability causing them to be unable to sign pages with original signatures.

Medicare Billing Time Limits -

At the time of this writing, doctors have one year from the date of service to submit both original as well as resubmission claims. Resubmission claims include corrected claims, but could also be claims not received by Medicare. Appeals (also known as Redeterminations) of denied claims or unfavorable outcomes of claims must be submitted within 120 days of the date of denial. Reconsiderations are the second level of appeal, and must be submitted within 180 days from the date of the appeal. There is no charge for original submissions of claims, resubmissions, appeals, or reconsiderations. Failure to submit billing within these time limits results in non-payment.

The next level of appeal is an Administrative Law Judge Hearing, and the time limit to apply is 60 days from the date of the outcome of the reconsideration. Administrative law judge hearings have a cost to the doctor of $140.00. The next and last level of appeal is the Medicare Appeals Council Review, and the time limit to apply is also 60 days from the date of the outcome of the administrative law judge hearing, and will cost the doctor $1,400.00. There obviously becomes a point in time where the cost of an appeal outweighs the potential for a favorable outcome, especially when roughly only $25.00 per adjustment is at stake.

Medicare sanctions -

The Medicare Secretary is required to monitor the actual charges submitted by each Medicare provider and supplier. If a Medicare provider or supplier knowingly and willfully bills above Medicare's limiting charge, the Secretary may apply sanctions, including 1) barring the Medicare provider or supplier from enrollment in the Medicare program for up to five years and/or 2) imposing a civil money penalty or assessment [Soc. Sec. Act §§1842(j)(1)(A), 1842(j)(2)]. As stated in the previous paragraph, those providers and suppliers who fail to either submit a claim as required or who impose

charges for completing claims are subject to Medicare sanctions of up to $2,000 per violation, exclusion from the Medicare program, and/or a 10% reduction in future payments [Soc. Sec. Act. §1848(g)(4), *Medicare Claims Processing Manual*, Pub. 100-04, Ch. 1, §70.8.8.6].

Medicare Fraud and Abuse Penalties -

Several government agencies work jointly to combat fraud, abuse, and waste in the federal health care programs. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Health Care Fraud and Abuse Control Program under the joint direction of the U.S. Attorney General and the Department of Health and Human Services (HHS) acting through the Office of the Inspector General (OIG). While the statute broadly defines health care fraud to cover fraud in all health care programs both public and private, the OIG's role is limited to Medicare and Medicaid. [Soc. Sec. Act §1128C]. The Patient Protection and Affordable Care Act (PPACA) added a number of new provisions to augment the government's ability to control fraud and abuse. Any doctor who has completed Medicare's recredentialing process since the PPACA has been effective has seen the result of this new law with a significantly increased amount of information required to be provided to Medicare.

A D.C. convicted of Medicare fraud can suffer both civil and criminal consequences, which should also result in revocation of licensure by the Board. While fraud and abuse laws include a variety of different civil and criminal statutes, as well as the involvement and oversight of federal, state, and local investigatory agencies, the following federal laws are the most common ones used to prosecute Medicare abuses:

1) the Medicare-Medicaid Anti-Fraud and Abuse Amendments,
2) the criminal federal False Claims Statute,
3) the civil federal False Claims Act,
4) civil monetary penalties and assessments,
5) exclusion from Medicare participation, and
6) physician self-referral prohibition (Stark laws).

Anyone convicted of a felony involving Medicare is subject to criminal penalties, including both imprisonment and a fine of between $1,000 and $25,000. Activities causing a doctor or other person to be subject to these penalties include knowingly and willingly making or causing to be made the following:

1) false statements [Soc. Sec. Act. §§1182B(a & c),
2) false statements about a facility [Soc. Sec. Act §1182B(c)],
3) false representations about Medicare [Soc. Sec. Act §1107(a)], and
4) false representation [Soc. Sec. Act §1107(b)].

HIPAA law amended Chapter 1 of Title 18 U.S.C., by adding section 24 and defining the term "federal health care offense" to include the following violations of Title 18:

1) knowingly or willfully defrauding or attempting to defraud a health care benefit program (resulting in up to 10 years imprisonment, fines, or both) [18 U.S.C. §1347],
2) stealing assets of a health care benefit program (resulting in up to 10 years imprisonment, fines, or both) [18 U.S.C. §669],
3) knowingly and willfully concealing material facts or making false statements in any manner concerning a health care benefit program (resulting in up to 5 years imprisonment, fines, or both) [18 U.S.C.§1035],
4) obstructing a federal criminal investigation of a federal health care offense (resulting in up to 5 years imprisonment, fines, or both) [18 U.S.C.§1518], and
5) engaging in the laundering of monetary instruments related to a federal health care offense faces both criminal and civil penalties , including automatic asset forfeiture [18 U.S.C. §§1956(a)(1), 1956 (c)(7)(F)].

Additionally, the Secretary of Health and Human Services (HHS) is authorized to render administrative sanctions in the form of civil monetary penalties of the following:

1) up to $10,000 for each item or service fraudulently claimed,
2) $15,000 for false or misleading information given, and
3) $50,000 for each false record or statement given,
4) up to three times the amount for each item or service claimed, and
5) suspension from participation in the Medicare program. [Soc. Sec. Act §1128(b)].

The lists of penalties under different federal laws continues forward and is numerous. The major point to be taken is not only is it obviously wrong to commit fraud, it can also be very expensive and greatly interfere with one's life. Some of these laws do not require a mental state of knowing or willingly committing the wrong act, and instead merely requires the commission of the wrongdoing. The bottom line is that crime isn't worth doing it, or as otherwise said crime doesn't pay.

How to Get Out of Medicare as an Enrolled Provider -

Doctors of chiropractic are the only type of health care provider in the Medicare Part B program that cannot opt out of the program. Opting out is the rapid process for becoming unenrolled as a provider of Medicare services, which can be done by most other Medicare providers by simply stating in writing that they no longer desire to be enrolled as a provider of services in the Medicare program.

However, there are two ways for doctors of chiropractic to become unenrolled from the Medicare Part B program. Both ways are the back door ways of getting out of the program, so to speak. All that the chiropractor has to do is to not submit any billing to Medicare for at least eight consecutive quarters. Soon after that time has occurred, Medicare will automatically unenroll the doctor based on inactivity with the program. The other way to become unenrolled by Medicare is to have an error (which is subsequently uncorrected) as part of the recredentialing forms.

Remember that the previously discussed mandatory claims submission requirement means that the doctor of chiropractic is generally required to submit billing for spinal adjustments performed on Medicare beneficiaries, unless the patient refuses to allow the doctor to submit billing to Medicare. The chiropractor will need proof that the patient has prohibited them from billing Medicare. Although this proof can be any patient signed statement to that effect, Medicare will readily recognize it own ABN form with option 2 checked as previously described. Once the doctor receives a letter from Medicare informing them they are no longer enrolled as a provider of services in the Medicare Part B program, they are out. Due to being no longer enrolled, they are then prohibited from submitting any bills to Medicare, they can treat Medicare beneficiaries just like any other person, and are no longer restricted by Medicare's limiting charge as to what they can collect for spinal adjustments performed on Medicare beneficiaries.

Because a doctor was unenrolled based on inactivity, there should be no adverse consequences resulting from this action. However, exclusion from the Medicare program is the term used for being kicked out of the Medicare program based on wrongful acts. The former is analogous to an honorable discharge from the military, and the later is analogous to a dishonorable discharge from the military.

Medicare Audits -

DO NOT IGNORE MEDICARE AUDITS. This special comment is needed because too many adverse results of audits toward a given doctor will result in exclusion from the Medicare program. Keep in mind that exclusion is analogous to a dishonorable discharge from the military, and carries a heavy connotation. For example, a doctor who applies to or is contracted with an insurance company, preferred provider organization, health maintenance organization, or insurance umbrella group will probably be required to reveal whether they have removed from participation in any manner, especially if due to any negative circumstances. Being excluded from Medicare can result in expulsion or termination from other insurance contracts.

This author has endured one Medicare audit, and it is worth mentioning based on a number of lessons to be learned. There was a patient who early in the morning in their own home fell down, hit their head, and suffered headaches and neck pain as a result of that fall. This patient was seen for all of five visits, each which involved spinal adjustments only. A copy of the chart notes WITHOUT the doctor's signature was included along with the bill on one billing page for a total of $141.25. A check in the full amount of $141.25 was received by the doctor and promptly deposited in his checking account. About three months later, a letter from Medicare was received demanding a full refund of $141.25. That letter stated that this payment was received in error and that the doctor is responsible for being aware of correct claim filing procedures. It declared the doctor was therefore a debtor to the United States of America, and that interest would accrue at 10 7/8 % per year if not repaid within 30 days. It stated deadlines for filing a timely redetermination and for a subsequent reconsideration if necessary. The doctor spent 1 1/2 hours drafting a letter explaining why the care for 5 spinal adjustments was necessary (which as was revealed later was not the issue), but the redetermination was made in favor of Medicare. The doctor then called Medicare, spoke to a claims adjuster, and asked what was the problem. The claims adjuster explained there needed to be an original signature by the doctor on any page other than original billing pages. After spending considerable more time to put together the second appeal (reconsideration) including signatures on all pages other than billing pages, the reconsideration was made in the doctor's favor.

The doctor thought that the successful reconsideration (from the doctor's perspective) would have ended the matter, but it didn't. Several months after the reconsideration, the doctor received a NEW Medicare check in the amount of $141.25 for the same patient with the same dates of service. The doctor called Medicare, explained the situation, and the claims adjuster attempted to get the doctor to search for a particular form online, complete that form, and mail it with the check back to Medicare. The doctor didn't care to play that game, and instead told the claims adjuster he had already written the word "VOID" numerous times on both the front and back side of the check, that he didn't have time to play that game, and that the voided check would promptly be mailed back to Medicare.

Keep in mind that California Board of Chiropractic Examiners Rule and Regulation Article 2, section 316(a) makes doctors of chiropractic responsible for all conduct in their chiropractic place of business. It is a good idea to accurately maintain billing records so as to spot a duplicate payment. It is much better to return an undeserved check than it is to refund an already deposited check.

Retention of Records -

Medicare requires all patient records (including written and radiology records) to be kept until seven years after the date of the last explanation of benefits page received from Medicare. Because Medicare is a federal insurance program, its laws, rules and regulations usurp state laws, rules, and regulations when treatment is rendered to a Medicare beneficiary. It is important to ask patients if they are Medicare beneficiaries, and it must be remembered that Medicare provides benefits to disabled persons as well as elderly persons. Therefore, it is possible a person younger than age 65 could be a Medicare beneficiary.

Not in reference to Medicare and only provided from a point of information standpoint, the retention of records for non-Medicare beneficiaries is governed by state law. In California, the Board of Chiropractic Examiners requires written records to be retained for five years from the last date of service unless any other laws, rules, or regulations require longer retention times. However and additionally, the California Department of Public Health, Radiologic Health Branch requires radiology records to be retained for seven years after the date of discharge of the given patient.

About the Author -

Dr. David H. Hofheimer, D.C., Esq. is committed to the empowerment and service to others by actively and enthusiastically practicing personal injury and trial litigation law, continuing to practice chiropractic since 1991 and practicing law since 2010, and teaching continuing education relicensing seminars as an attorney to fellow chiropractors. With his major emphasis as an active full time personal injury and trial litigation attorney, he is at the present time the only active plaintiff personal injury attorney in all of northern California who is concurrently licensed in the state of California as both a doctor of chiropractic and an attorney at law. Dr. Hofheimer has as his purpose as a practicing lawyer

the intention to empower the chiropractic profession and to maximize and protect peoples' legal rights, including those of fellow chiropractors and their patients. He has as his purpose as a practicing chiropractor the intention to have patients be well naturally through chiropractic. He makes himself available to all good chiropractors for anything related to chiropractic and law, as he would much rather have doctors of chiropractic prevent problems than have to deal with them. Feel free to contact Dr. Hofheimer at (707)-745-9700.