Essential Requirements and Communications for the Chiropractic Office

Mind expansion in process...

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Certified Professional Compliance Officer
www.Askmario.com

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The laws, rules and regulations regarding the establishment and operation of a healthcare facility vary greatly from state to state and are constantly changing. Dr. Mario Fucinari does not engage in providing legal services. If legal services are required, the services of a healthcare attorney should be attained. The information in these seminar slides is for educational purposes only and should not be construed as written policy for any federal agency.

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Disclaimer: The views and opinions expressed in this presentation are solely those of the author, Mario Fucinari DC, CPCO, CPPM, CIC. We do not set practice standards. We offer this only to educate and inform.

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About Dr. Mario Fucinari, DC, CPCO, CPPM, CIC

- President, Ask Mario DC Consultants, LLC
- Certified Professional Compliance Officer (CPCO)
- Certified Physician Practice Manager (CPPM)
- Certified Insurance Consultant (CIC)
- Post-Graduate Faculty, Palmer College of Chiropractic, Logan College, Northeast College of Health Sciences (NYCC), Life West, NUHS, D'Youville College, Logan College, and Northwestern Chiropractic College
- Member, Medicare Carrier Advisory Committee
- National Speaker's Bureau for NCMIC, CHUSA and Foot Levelers
- Past Recipient Chiropractor of the Year

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- Follow Dr. Fucinari on facebook for the latest in compliance, coding and Medicare.
- Be a friend. "Like" us at **facebook.com/askmario**
- Put us in your notifications

Ask Mario
FOOT LEVELERS

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Know the Requirements

Running a successful chiropractic office requires a clear understanding of coverage standards of Medicare, commercial insurance, state Chiropractic Board of Examiners and HIPAA regulations, and how to bill for those services.

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Rising Concerns In Reimbursement Rates

- Physicians are not paid based on actual value of the services they provide.
- Chiropractic offices are being challenged with increased state and Federal regulations.
- Reimbursement rates have failed to keep up with inflation, increased work demands, and increased employee wages and benefits.
- It is essential for Chiropractors and staff to communicate the need for Chiropractic Care to their patients, without losing the doctor-patient relationship.

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Standard of Care

"The type and level of care an ordinary, prudent, health care professional, with the same training and experience, would provide under similar circumstances in the same community."

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Required Compliance Documents

- **Corporate Compliance Manual**
  - Policies and Procedures
  - Non-Retaliation Policy
  - Non-Harassment Policy
  - Staff Training Required
- **HIPAA Manual**
  - Privacy Policy
  - Business Associate Agreement
  - Staff Training Required

LIVING DOCUMENTS
www.AskMario.com

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OIG GUIDELINES

Seven Elements of Your Compliance Program

1. Designate a compliance officer;
2. Implement Written Policies and Procedures;
3. Conduct comprehensive training and education;
4. Develop accessible lines of communication;
5. Conduct internal monitoring and auditing;
6. Enforcing standards through well publicized disciplinary guidelines; and
7. Responding promptly to detected offenses and undertaking corrective actions.

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Auditing and Monitoring

1. Auditing
   a) Implement risk evaluation and auditing techniques
   b) Best if done by an outside entity so as not to be biased
   c) Must be independent and objective

2. Monitoring
   a) Based on assessment of risk
   b) Used as a management tool
   c) Day-to-day activities within the office
   d) Scalable to the risks and resources

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OIG GUIDELINES

The Eighth Element added is that all employees must be checked against the OIG Exclusion Database

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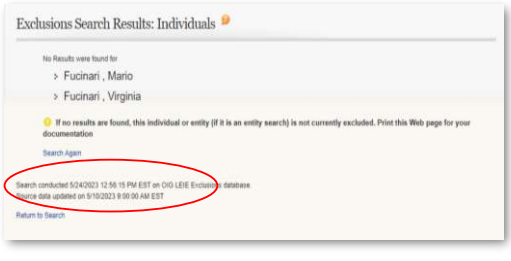

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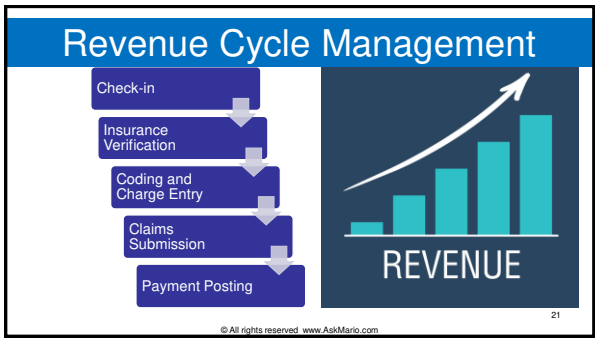

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Revenue Cycle Management

The Journey begins *before* the Check in… Pre-Check

Ask Questions

Pre-Service for the scheduled patients

Collect as much information as possible

Insurance Verification

Communicate costs and collect if possible

Explain financial obligations and plans if necessary

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At the Initial Call for an Appointment

- Set the expectations
- Be *Gentle*!!
- ~~Have you been here before?~~
- When was the last time you were in to see the doctor?
- Verify the contact information
- Verify spelling of their *LEGAL* name
- Insurance Verification
- Are we in their network?
- Insurance counseling
- Social security number (VA)
- DOB
- Primary card holder
- Deductibles?
- Co-pays?
- Get paperwork to the patient
- Give specific directions to the office (Tie it in with a know location)

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Revenue Cycle Management

Verify Information

"We would like to assist you by contacting your insurance company for coverage details prior to your visit"

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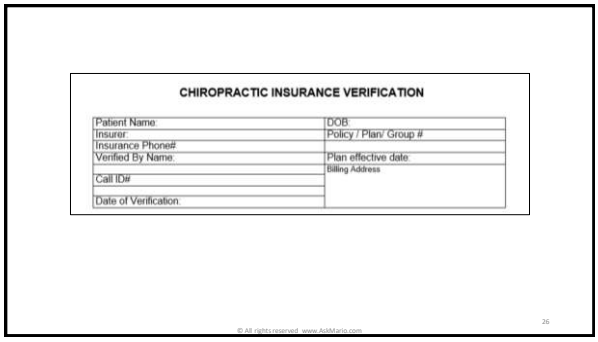

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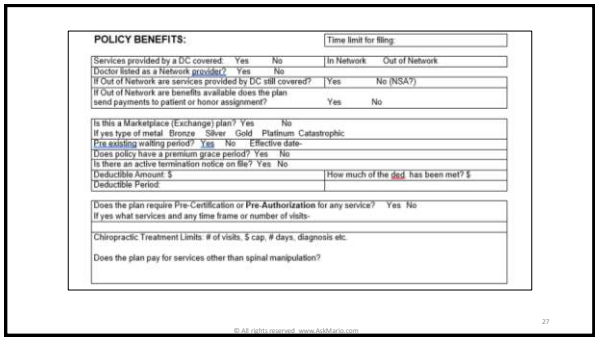

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Specific Covered Services	Co-Pay	Co-Insurance	NC or Limit
E/M Services 99202-99205 99211-99215			
X-Ray			
Chiropractic manipulation 98940-98942 98943			
Therapeutic exercise 97110			
Therapeutic activities 97530			
Massage 97124			
Manual therapy 97140			
Electrical stimulation 97014 or G0283			
Mechanical traction 97012			
Are PMR services payable when rendered by staff or LMT under DC direct supervision? Yes No			

NC = No Coverage Limit = max visits allowed

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Permission to Treat a Minor

CONSENT TO TREATMENT OF MINOR

I(We), the undersigned, parent(s)/person having legal custody/legal guardianship of _____, a minor, do hereby authorize _____ (name of minor) (name of agent) _____ as agent(s) for the undersigned to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

This authorization shall remain effective until _____, 20____ unless sooner (month and day) revoked in writing delivered to the agent(s) noted above.

Date: _____

Signature: _____ (parent/legal guardian/person having legal custody) (circle relationship)

Signature: _____ (parent)

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Financial Policies

OFFICE FINANCIAL POLICY

Our policy is that following a preliminary exam, any services rendered by this office on the initial visit shall be paid for at that time unless other arrangements have been made in writing. Our office is pleased to accept your insurance assignment as soon as the responsible party verifies your exact coverage. However, it must be fully understood that the contract is between you and your insurance company. You are fully responsible for any amounts not paid by your insurance.

Our office policy is as follows:

1. Since we have to await payment by taking your insurance assignment, this courtesy may be withdrawn if warranted.
2. The deductible amount must be paid in full before billing.
3. Insurance payments should be made every 30 days the maximum time limit we extend is Sixty days, thus fees must be paid in full by the patient.
4. You are required to sign an "Authorization to Pay Physician" form and any other documents required by your insurance company.
5. Our office without guarantee that your insurance company will pay. At the beginning of your healthcare, we will make every attempt to receive verification of your policy coverage. However, if your claim is denied for any reason, you are responsible for the total amount due to this office.
6. This office will not enter into a dispute with your insurance company over your claim. It is your responsibility and obligation. We will, however, assist you in any way that we can.
7. You, the patient, must keep current with your insurance co-payment.
8. A 1.5% finance charge will be added to all accounts over 90 days old.
9. If your account is past due, it may be turned over to a collection agency. If our account is not paid in full and this account is turned over to a collection agency and/or attorney, then you agree to be responsible for all reasonable fees necessary for the collection agency fees of 10% of the balance due and costs and reasonable attorney's fees of 33% of the balance.
10. If the insurance company sends you payment for our services, it is your responsibility and obligation to bring to us a payment in full.

I have fully read and agree to this financial policy as written:

Signed: _____

Date: _____

Witness: _____

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4. You are required to sign an "Authorization to Pay Physician" form and any other documents required by your insurance company.
5. Our office **will not** guarantee that your insurance company will pay. At the beginning of your healthcare, we will make every attempt to receive verification of your policy coverage. However, if your claim is denied for any reason, you are responsible for the total amount due to this office.
6. This office will not enter into a dispute with your insurance company over your claim. It is your responsibility and obligation. We will, however, assist you in any way that we can.
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9. If your account is past due, it may be turned over to a collection agency. If our account is not paid in full and this account is turned over to a collection agency and/or attorney, then you agree to be responsible for all reasonable fees necessary for the collection agency fees of 50% of the balance due and costs and reasonable attorney's fees of 33% of the balance.
10. If the insurance company sends you payment for our services, it is your responsibility and obligation to bring to us a payment in full.

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Credit Card Policies

- If your practice collects patient billing information, you are considered a 'merchant' and are subject to federal and state laws and regulations that protect consumer credit card information.
- These laws and regulations include Health Insurance Portability and Accountability Act (HIPAA); Federal Trade Commission Act (FTCA); and Payment Card Industry Data Security Standard (PCI DSS), which was not devised by the federal or state government.
- Health Insurance Portability and Accountability Act (HIPAA) and state privacy laws require providers to implement 'reasonable' security measures to protect payment information.
- Using HIPAA-compliant encrypted storage programs (for electronic storage) are examples of 'reasonable' security measures.

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Credit Card Policies

- Federal law requires all businesses to delete a card's expiration date and shorten the account information to include no more than the last 5 digits of the card number that is printed on all sales receipts.
- FTCA also requires businesses to get prior authorization from individuals before charging their credit cards. For example, if a patient previously used a credit card to pay for a session, the psychiatrist cannot later use the credit card to charge for a missed appointment without notifying the patient and getting their authorization.
- Payment Card Industry Data Security Standard (PCI DSS) applies to entities that store, process, and/or transmit cardholder data. Examples of the PCI DSS rules include using firewalls to protect cardholder data and restricting access to cardholder data to a 'need-to-know' basis. Businesses that do not comply with PCI DSS can be subjected to fines and/or have their contracts terminated by credit card companies.

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Virginia Lien Law

- **Virginia Code Section 8.01-66.2** provides health care providers with a lien against the person, firm, or corporation whose negligence caused your person injuries. Health care providers covered under this section include: public hospitals; private hospitals; nursing homes; physicians; nurses; physical therapists; pharmacists; chiropractors; and, emergency medical services and transportation.
- The statutory health care provider lien in Section 8.01-66.2 is not perfected **unless written notice of the lien is given to the injured person's attorney or to the person**, firm, or corporation whose negligence caused the person's injuries. Virginia Code Section 8.01-66.5. **If the medical provider fails to give written notice then it does not have a valid lien.**

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Virginia Lien Law

- If an attorney receives notice of the health care provider's lien and does not satisfy the lien out of the personal injury settlement or proceeds, then the lien holder may pursue a claim against the attorney. The attorney's liability is limited to the amounts provided in Virginia Code Section 8.01-66.2, unless a state-run medical facility is the lien holder. Because of the liability and ethical responsibilities imposed on your attorney, he or she will not release funds to you until all lien issues are resolved.

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OFFICE NAME
ADDRESS
CITY, STATE, ZIP
Phone: (XXX) XXX-XXXX Fax: (XXX) XXX-XXXX

NOTICE OF HEALTH CARE PROFESSIONAL IRREVOCABLE LIEN

Date: _____

To: _____

To: _____

To: _____

To: _____

Dear Sir or Madam:

You are hereby notified that or the physician who rendered treatment to

Name of Injured Person: _____

Address: _____

I am claiming a lien upon all claims and causes of action for the amount of my reasonable charges, up to the date of payment of such damages, not to exceed the maximum allowable under the [C. §] 32.1-4.1 – 8, Noncivil Liens Statute.

Date of Injury: _____, 20

Physician Signature

Physician Name

Physician Address
OFFICE NAME, ADDRESS, CITY, STATE, ZIP

** CERTIFIED MAIL – RETURN RECEIPT REQUESTED

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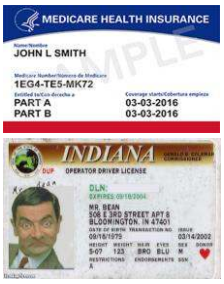
Verify Insurance and Identity



The Medicare Card
- Name
- Medicare Number
- Effective date of entitlement

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- Photocopy/scan the front and back of the member's ID card.
- Check eligibility and benefits

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- Some cards may feature an employer's name or logo
- Copay amounts are not shown on the card.
- If present, a QR code on the BCBS ID cards will link to the members Schedule of Benefits Summary. This will tell you about in-network and out-of-network deductibles and out-of-pocket maximums.

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- The PPO suitcase logo indicates that the member is enrolled in either a preferred provider organization (PPO) plan or an exclusive provider organization (EPO) plan.
- In either case, you will be reimbursed according to your network provider agreement.

- The EMPTY SUITCASE logo indicates the member is enrolled in one of the following types of plans: traditional HMO or POS.
- No suitcase for Medicaid, SCHIP, Medicare Supplement

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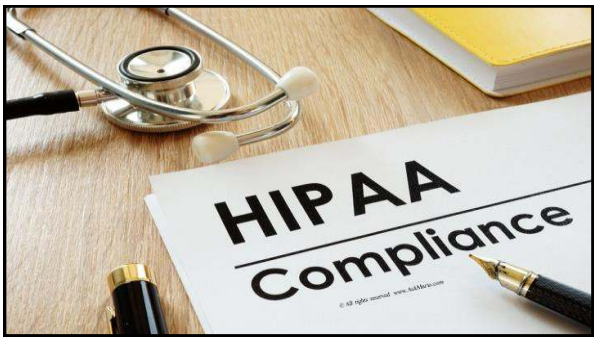

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RISK ASSESSMENT

"The most appropriate means of compliance for any covered entity can only be determined by that entity assessing its own risks and deciding upon the measures that would mitigate those risks"

-Department of Health and Human Services

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RISK ASSESSMENT

Required to be done and documented.

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HIPAA Rules

- Congress gave us the law
- HHS gave us Privacy Rules (April 15, 2003) and Security Rules (April 20, 2005).
- **Establish officers in your office:**
  - **Privacy Officer**
  - **Security Officer**
  - **Complaint Officer**

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Compliance Training

- ***ALL*** members of your office are to be trained on the HIPAA, Corporate Compliance, and Cures Act compliance rules.
- This includes admin, doctor(s), staff, volunteers and others who come in contact with patient information
- If you hire someone new, then they must be trained within a *reasonable* time after being hired.

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Compliance Training

Required Compliance Training Documentation:

- Training source
- Date of training
- Notes of training
- Attendees' names must be filed with the Compliance Officer and in the employment file for each person.
- Document your policies and procedures.
  - Customize your policies and procedures
  - Be specific in documentation of the policy and the procedure

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HIPAA – Privacy Policy- General Rule (164.502)

A covered entity may not **use** or **disclose** protected health information except as permitted or required by this subpart or by subpart C of part 160 of this subchapter.

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Uses and Disclosures (160.103)

- **Uses** – information shared within the covered entity.
- **Disclosures** – sending information outside of the entity
- A covered entity may use/disclose PHI to carry out essential health care functions for TPO
  - **T**reatment
  - **P**ayment
  - Health Care **O**perations

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Patient Sign-in Process

- Confidentiality is key.
- HIPAA concerns
- Are Sign-in Sheets confidential?
- Do you mark through the name with a dark marker?
- Do you use a label?
- Electronic sign-in?
- Assign patient a number and call them back by number?

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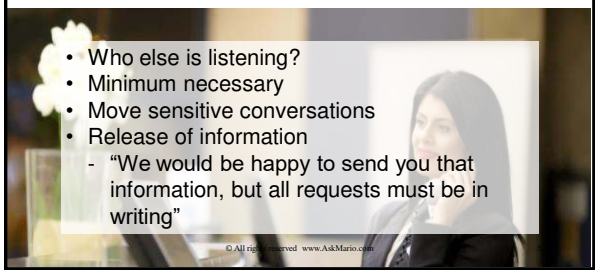
HIPAA Telephone Considerations



- Who else is listening?
- Minimum necessary
- Move sensitive conversations
- Release of information
  - "We would be happy to send you that information, but all requests must be in writing"

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The HIPAA Privacy Notice

HIPPA PRIVACY POLICY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated. If you have further questions, please contact Mario Fraziani D.C.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.

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Required Elements of the Privacy Notice

b. Header - Must use the specific language in the header as provided by the law.

   "This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully."

c. Uses and Disclosures – Describe all the uses of the information for which you are not required to have an authorization.

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The Provision of the Privacy Notice

- The notice must be posted "**in a prominent location**."
- The notice *must* be posted on your **web site**.
- The covered entity must provide a notice upon the request from *any* person.
- The patient will sign an acknowledgment that they were offered the privacy policy to read.
- If the acknowledgment is not signed, you must document why the acknowledgement was not obtained.

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HIPAA COMPLIANCE

- Patient Emergency Contact Information
  - –Update at least annually
- Alternate Contacts?
- Voice Mail Restrictions
- **Permission to Text**
- **HIPAA Privacy Acknowledgement**

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In case of emergency, who may we contact or release information to on your behalf? Do you give permission to the doctor or staff to discuss your medical condition and information about your care with any family members or friends? If yes, please provide names and contact information below.

NAME	RELATIONSHIP	TELEPHONE NUMBER

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HIPAA COMPLIANCE

Open Adjusting Patients

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. There are various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open door" environment are incidental matters. You may choose to be adjusted in our private room.

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HIPAA COMPLIANCE

Security Cameras in the Office

- Security cameras at the front and back entrances are generally acceptable as these are considered public areas. Nonetheless these should be accompanied with a highly visible notice that the areas are being monitored by video surveillance.
- When using security cameras, you must ensure that they don't compromise patients' protected health information (PHI). Keep in mind that PHI not only encompasses information in the clinical records, but also biometric identifiers including voice prints and full-face photographic images.

Source: NCMIC. www.ncmic.com/insurance/malpractice/risk-management/what-dcs-should-know-about-security-cameras-and-hipaa/

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HIPAA COMPLIANCE

Security Cameras in the Office

To mitigate a HIPAA violation or allegation of a PHI breach, make sure not to install the video cameras in private areas (such as exam rooms). Additionally, take care that there is no possibility of the public viewing any recorded information. Create a policy and procedure for your staff regarding the use of, management and disposal of the cameras/recordings. It also can be beneficial to identify:

- Who will have access to the recordings
- How long the recordings will be kept
- Where the recordings will be kept
- How the recordings will be disposed of (disposal must be consistent with disposing other PHI, if present)
- How recordings will be released in the event of a request to prevent the unintentional release of other PHI
- How to prevent hacking
- What encryption is used if video is stored
- When to obtain a business associate agreement If cameras will be monitored by a third party
- What HIPAA training is needed for staff who has access to PHI in the recordings

Source: NCMIC. www.ncmic.com/insurance/malpractice/risk-management/what-dcs-should-know-about-security-cameras-and-hipaa

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HIPAA Notice Acknowledgement

HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

This authorization is prepared according to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191, 42 U.S.C. Section 1320d, et. seq. and regulations thereunder, as amended from time to time (collectively referred to as "HIPAA"). This authorization affects your rights in the privacy of your personal healthcare information.

By signing this authorization, you acknowledge and agree that this Chiropractic ("Practice") or its Business Associates may use or disclose your Protective Health Information (PHI) to provide treatment, for purposes of relating to the payment of services rendered, and for the Practice's healthcare operations purposes.

Further, by signing this authorization, you acknowledge that you have been provided a copy of and have read and understood this Chiropractor's Privacy Notice containing a complete description of your rights and the permitted uses and disclosures under HIPAA. While this office has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available and can be received by sending a written request with the return address to the center where you were seen.

By signing below, you are acknowledging that you have received, reviewed, understand and agree to the Notice of Privacy Practices of this Chiropractic office, which describes the Practice's policies and procedures regarding the use and disclosure of any of your Personal Health Information created, received, or maintained by the Practice.

Acknowledged and agreed to by:

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Section 1557 of PPACA

- Section 1557 is intended to promote equity in health care and prevent discrimination on the basis of **race, color, national origin, religion, sex, age, or disability** in health programs or activities that receive federal financial assistance.
- Compliance requires posting certain notices in your office and there are consequences for failure to do so if you are not exempt.

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Section 1557 of PPACA

Section 1557 Requirements are as follows:

- Having a Section 1557 compliance coordinator;
- Having a Section 1557 grievance process;
- **Posting new notices** - in your building, on your website and in certain publications/communications - on nondiscrimination, available assistance and patient rights;
- **Posting taglines -** in your building, on your website and in certain publications/communications - on the availability of language services in the top 2 non-English languages spoken in your state;
- Treating patients in a manner consistent with their gender identity;
- Not denying care to a patient based on sex, which includes their gender identity and sex stereotyping; and
- Providing equal access to communications and electronic and information technology for individuals with disabilities.

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Non-Discrimination Notice

Our office does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, religion, disability, sex, or age in admission to, or receipt of the services and benefits.

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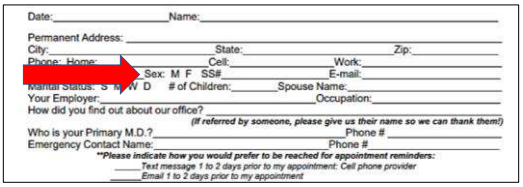
Intake Form Assessment



Date:_____Name:_____

Permanent Address: _____

City:_____State:_____Zip:_____

Phone: Home:_____Cell:_____Work:_____

Birth Date:_____Sex: M F SS#_____E-mail:_____

Marital Status: S M W D # of Children:_____Spouse Name:_____

Your Employer:_____Occupation:_____

How did you find out about our office? _____

(If referred by someone, please give us their name so we can thank them!)

Who is your Primary M.D.?_____Phone # _____

Emergency Contact Name:_____Phone #_____

Please indicate how you would prefer to be reached for appointment reminders:

_____*Text message 1 to 2 days prior to my appointment: Cell phone provider*

_____*Email 1 to 2 days prior to my appointment*

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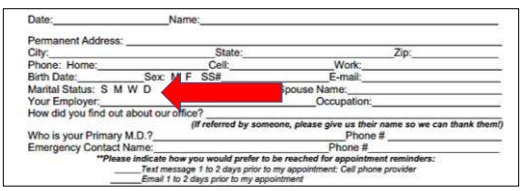
Intake Form Assessment



Date:_____Name:_____

Permanent Address: _____

City:_____State:_____Zip:_____

Phone: Home:_____Cell:_____Work:_____

Birth Date:_____Sex: M F SS#_____E-mail:_____

Marital Status: S M W D Spouse Name:_____

Your Employer:_____Occupation:_____

How did you find out about our office? _____

(If referred by someone, please give us their name so we can thank them!)

Who is your Primary M.D.?_____Phone # _____

Emergency Contact Name:_____Phone #_____

Please indicate how you would prefer to be reached for appointment reminders:

_____*Text message 1 to 2 days prior to my appointment: Cell phone provider*

_____*Email 1 to 2 days prior to my appointment*

 66

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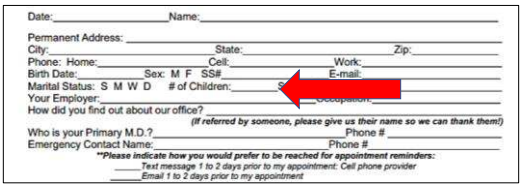
Intake Form Assessment



Date:_____Name:_____

Permanent Address: _____

City:_____State:_____Zip:_____

Phone: Home:_____Cell:_____Work:_____

Birth Date:_____Sex: M F SS#_____E-mail:_____

Marital Status: S M W D # of Children:_____S[redacted]_____

Your Employer:_____Occupation:_____

How did you find out about our office?_____

(If referred by someone, please give us their name so we can thank them!)

Who is your Primary M.D.?_____Phone # _____

Emergency Contact Name:_____Phone #_____

Please indicate how you would prefer to be reached for appointment reminders:

_____*Text message 1 to 2 days prior to my appointment: Cell phone provider*

_____*Email 1 to 2 days prior to my appointment*

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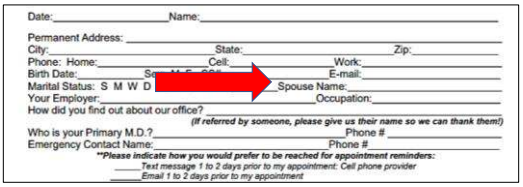
Intake Form Assessment



Date:_____Name:_____

Permanent Address: _____

City:_____State:_____Zip:_____

Phone: Home:_____Cell:_____Work:_____

Birth Date:_____S[redacted]E-mail:_____

Marital Status: S M W D _____Spouse Name:_____

Your Employer:_____Occupation:_____

How did you find out about our office?_____

(If referred by someone, please give us their name so we can thank them!)

Who is your Primary M.D.?_____Phone # _____

Emergency Contact Name:_____Phone #_____

Please indicate how you would prefer to be reached for appointment reminders:

_____*Text message 1 to 2 days prior to my appointment: Cell phone provider*

_____*Email 1 to 2 days prior to my appointment*

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Intake Form Best Practices for LGBQT Patients

My pronouns are _____

Alternatively, you may choose from the following options

- O He/him/his
- O She/her/hers
- O They/them/theirs
- O Ze/hir
- O Another pronoun: _____

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Revenue Cycle Management

- **Verify** – Verify patient information by asking the patient to TELL you the information
- **Copy** – Copy the patient's insurance card and identification
- **Confirm** – Confirm all information collected at pre-service
- **Collect** – Collect co-pay if due
- **Discuss** – Discuss any billing concerns

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Insurance Definitions

- **Deductible** – A *contractual* obligation the patient pays for covered health care services before the insurance plan starts to pay.
- **Co-insurance** - The percentage of costs of a covered health care service the patient pays (20%, for example) after they meet their deductible.
- **Co-pay** – A *contractual* obligation the patient pays each visit. Usually a fixed amount ($20, for example) they pay for a covered health care service. The patient *must* pay it at the time of service.

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Opting out of Medicare

"Opting out of Medicare is not an option for Doctors of Chiropractic. Note that opting out and being non-participating are not the same things. Chiropractors may decide to be participating or non-participating with regard to Medicare, but they may not opt out."

MedLearn Matters SE0479

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Filing of Medicare Claims

Medicare Processing Manual §70.8.6 – Time Limitation for Filing Part B Reasonable Charge and Fee Schedule Claims (Rev. 170, 05-07-04)

- Medicare law prescribes specific time limits within which claims for benefits may be submitted with respect to physician and other Part B services payable on a reasonable charge or fee schedule basis
- For these services, the terms of the law require that the **claim be filed no later than one year from which the service was furnished.**

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Timely Filing Deadlines

- Medicare Part B – one year from the date of service
- Medicare Part C – 90 days from the date of service
- BCBS – 6 months from the date of service

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NEW!

Are you in compliance with Qualified Medicare Beneficiary (QMB) billing requirements?

People with Medicare who are in the QMB program are also enrolled in Medicaid and get help with their Medicare premiums and cost-sharing. **Medicare providers may not bill people in the QMB program for Medicare deductibles, coinsurance, or copays, but state Medicaid programs may pay for those costs.** Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. *(Released by CMS January 17, 2019)*

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Offering Gifts and Other Inducements to Beneficiaries

A person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services may be liable for civil money penalties (CMPs) of **up to $10,000 for each wrongful act.** The statute defines "remuneration" to include, without limitation, waivers of copayments and deductible amounts (or parts thereof) and transfers of items or services for free or for other than fair market value.

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Offering Gifts and Other Inducements to Beneficiaries

The OIG has interpreted the prohibition to permit providers to offer beneficiaries inexpensive gifts (other than cash or cash equivalents) or services without violating the statute. For enforcement purposes, inexpensive gifts or services are those that have a retail value of not more than **$15** individually, and no more than **$75** in the aggregate annually per patient.

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Verify the Insurance Information **when making the appointment, *before*** the patient comes in for the first visit

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According to your insurance carrier…

there is NO guarantee of coverage!!

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- *Our fee is our fee*
- *Your Insurance Contractual Obligation*
- *Have you heard of ChiroHealthUSA?*

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Whose Rules Should We Follow?

- Time of Service Discount Percentages are permitted in some states.
- Not always defined!
- OIG indicates 5-15% per 2009 opinion.
- PIP laws in some states prohibit charging more to PI patients than other patients.

NOTICE: STATE LAW DOES NOT SUPERCEDE FEDERAL REGULATIONS AGAINST GIFTS & INDUCEMENTS AND CHARGING LESS THAN FAIR MARKET VALUE!

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ChiroHealthUSA
The Network That Works for Chiropractic!

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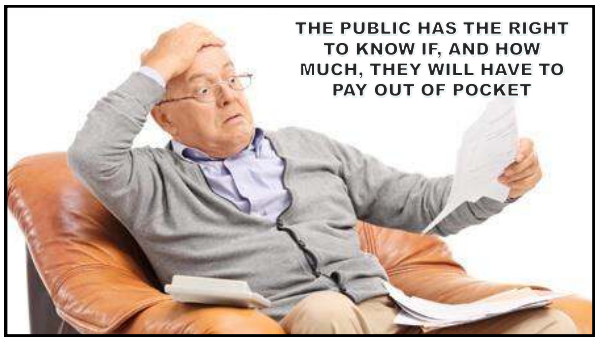

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- In **Medicare Part B, we have the ABN form** that informs patients that they are responsible for payment and transfers liability to them.
- For ALL others paying out of pocket, the No Surprises Act (NSA) mandates that a **Good Faith Estimate (GFE)** be given to the patient *before* services are rendered.

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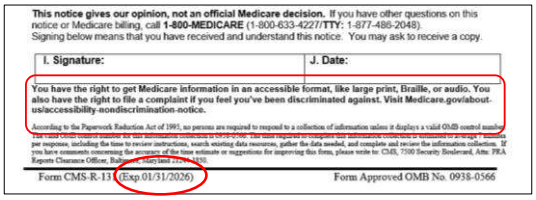

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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

https://www.cms.gov/medicare/medicare-general-information/bni/abn

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For Medicare Part B Non-Covered Services

Clinic/Doctor Name
Clinic Address
City, State, Zip, Telephone

Please be advised that your Medicare coverage for chiropractic only covers spinal manipulation that is deemed medically necessary. You are personally responsible for payment for services that are statutorily not covered. Services have been deemed medically necessary by the doctor but are not covered by your Medicare insurance. Those services include:

Examination (CPT 99202-99215)	$XX – $XXX
X-rays	$XXX
Electric muscle stimulation (G0283)	$XX
Ultrasound (97035)	$XX

Signature: _____ Date: _____

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Clinic Name or Doctor Name, Clinic Address, City, State, Zip, Telephone Number

A. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for the services below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the services below.

Services	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.

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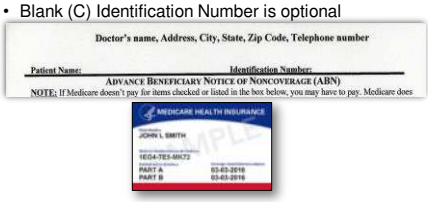
Patient Name:

- Notifiers must enter the first and last name of the beneficiary receiving the notice, and middle initial should also be used if on the beneficiary's Medicare (HICN) card.
- Blank (C) Identification Number is optional


Doctor's name, Address, City, State, Zip Code, Telephone number

Patient Name: Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does

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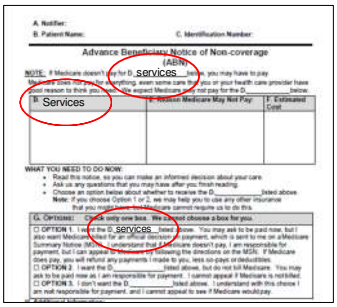
A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage

(ABN)

NOTE: If Medicare doesn't pay for D_services_ below, you may have to pay

B. Services

D. Reason Medicare May Not Pay: F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D_services_ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D_services_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the D_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ OPTION 3. I don't want the D_____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

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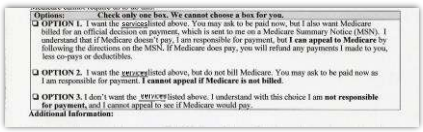
Options:

- These 3 checkboxes represent the beneficiary's possible choices regarding the potentially non covered care described in the body of the ABN.
- The beneficiary or representative must select only 1 of the 3 checkboxes. **Under no circumstances can the notifier decide for the beneficiary or representative which of the 3 checkboxes to select.**
- If a beneficiary chooses to receive some, but not all of the items or services that are subject of the notice, the items and services listed under Blank (D) that they do not wish to receive may be crossed out.


Options: **Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I want the services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

❑ **OPTION 3.** I don't want the services listed above. I understand with this choice I am **not responsible for payment,** and I cannot appeal to see if Medicare would pay.

Additional Information:

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Signature Box

- The beneficiary or representative must sign the notice, with his or her own name, in this box simply labeled "Signature", to allow maximum space for making the written entry. The signature indicates that he or she has received the notice and understands its contents.

Date:

- The beneficiary or representative must enter the date he or she signed the ABN.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:
John L. Smith	4/21/2024

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

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

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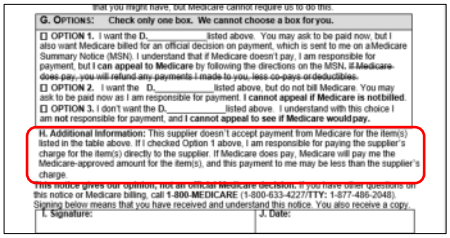
The Non-Par ABN



that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D._____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. ~~If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.~~

☐ **OPTION 2.** I want the D._____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the D._____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information: This supplier doesn't accept payment from Medicare for the item(s) listed in the table above. If I checked Option 1 above, I am responsible for paying the supplier's charge for the item(s) directly to the supplier. If Medicare does pay, Medicare will pay me the Medicare-approved amount for the item(s), and this payment to me may be less than the supplier's charge.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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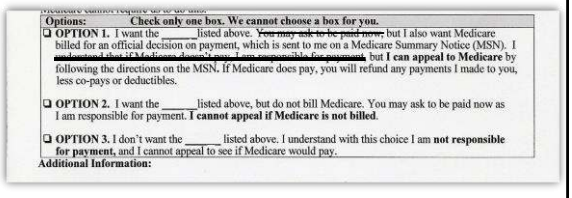
The Medicare QMB Patient



Options: Check only one box. We cannot choose a box for you.

❑ **OPTION 1.** I want the _____ listed above. ~~You may ask to be paid now,~~ but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I ~~understand that if Medicare doesn't pay, I am responsible for payment,~~ but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

❑ **OPTION 3.** I don't want the _____ listed above. I understand with this choice I am **not responsible for payment,** and I cannot appeal to see if Medicare would pay.

Additional Information:

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ABN Effectiveness Period

B. Period of Effectiveness

An ABN can remain effective as long as there is no change in the patient's health status. ABNs may describe treatment as long as no other triggering event occurs. If a new "triggering event" occurs within the 1-year period, a new ABN must be given.

See § 50.5 – Triggering Events.

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NO ABN Form for Part C Medicare Advantage Plans

- **CMS *expressly prohibits* providers from using the Advance Beneficiary Notice (ABN) or similar notices for Medicare Advantage (Part C) members.**
- CMS recommends that providers use the determination process established by the member's health plan. If there is a question about whether a Medicare Advantage plan will cover an item or service, members or their provider can request prior authorization/precertification before services or items are provided. If the request is denied, written determinations provide denial reasons and set forth appeal rights. If a provider chooses to provide a service to a Medicare Advantage member without first ensuring the service is covered, the provider must hold the member harmless.

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Medicare Advantage (Part C) Modifiers

MODIFIER	INDICATION
25	Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service.
GP	Services delivered under an outpatient physical therapy plan of care.
AT	Used on CMT codes (spinal) to indicate active care.

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NO SURPRISES ACT (NSA)

The No Surprises Act was passed with a goal to ensure that patients do not receive health care bills that far exceed their awareness or expectations.

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NO SURPRISES ACT (NSA)

Who does the NSA protect?

If the patient does not have insurance or they elect to self-pay for care, in most cases, these new rules make sure the patient gets a good faith estimate of how much their care will cost *before* they receive it.

- **Uninsured, Cash, Part C, PI, and Self-Pay Patients**

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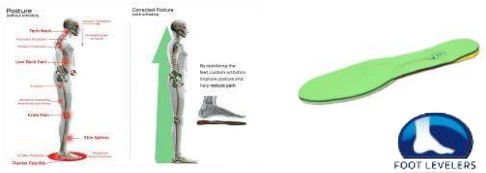
Not All Services the DOCTOR Recommends May be Covered by Insurance



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NSA Patient *Notification*

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NO SURPRISES ACT

How you must inform your patients of their rights

- Providers or facilities must post the "No Surprises Act Notice" prominently at the location of the facility and website in ***three s*pecific, clear, and understandable ways:**
  1. A **notice prominently displayed in the office** where patients can see the posting (Office Poster)
  2. A notice prominently displayed (and easily searchable from a public search engine) on your **website**, and
  3. **Orally** when a patient schedules an item or service or when questions about costs occurs.

(See templates)

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The NSA Notice

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

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Examples of *LINKS* on your website for the
- No Surprises Act
- HIPAA Privacy Policy
- Anti-Discrimination Notice

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How Do I Know What I Will Do on the First Visit?

- The GFE for the first visit could be the examination only, for example. However, if your GFE only estimated an evaluation, prudent policy would be not to do the service until the patient signs off on it.
- You do not want accusations of bait and switch.

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NO SURPRISES ACT (NSA)

Your GFE must be accurate

- For services provided, the actual amount charged must be within $400 of the GFE estimate you quote.
- If it appears that the final charges will be $400 or greater than the good faith estimate, then issue an additional GFE before the services are rendered.

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GOOD FAITH ELEMENTS

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The NSA Good Faith Estimate (GFE)

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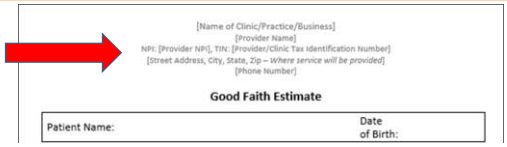
NSA Good Faith Estimate



1. Enter in the first name, last name, and title of providers and the legal name of the corporation or facility as written on their business license.
2. Enter in the physical address, city, state, and zip code for all providers and facilities involved in the expected period of care.
3. List the tax identification number and the NPI number of the provider or facility

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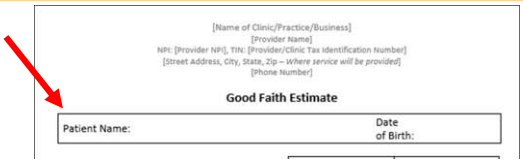
NSA Good Faith Estimate


[Name of Clinic/Practice/Business]
[Provider Name]
NPI: [Provider NPI], TIN: [Provider/Clinic Tax Identification Number]
[Street Address, City, State, Zip – Where service will be provided]
[Phone Number]

Good Faith Estimate

Patient Name: | Date of Birth:

4. First name, last name, and date of birth for the uninsured (or self-pay) individual receiving items or services.

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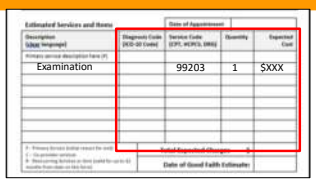
NSA Good Faith Estimate


Description	Diagnosis Code (ICD-10 Code)	Service Code (CPT, HCPCS, DRG)	Quantity	Expected Cost
Examination		99203	1	$XXX

6. List the diagnosis code (if known)
7. List the appropriate CPT or HCPCS along with the name of the service or item.
8. List the expected quantity of each item or service
9. List the expected charges associated with each item or service.

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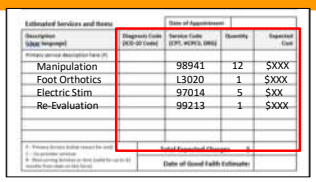
NSA Good Faith Estimate


Description	Diagnosis Code (ICD-10 Code)	Service Code (CPT, HCPCS, DRG)	Quantity	Expected Cost
Manipulation		98941	12	$XXX
Foot Orthotics		L3020	1	$XXX
Electric Stim		97014	5	$XX
Re-Evaluation		99213	1	$XXX

This could also be used in a Personal Injury Case to outline expected needed care in a CARE PLAN for permanent residuals over the next year, or in a maintenance program.

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NSA Good Faith Estimate

Estimated Services and Items		Date of Appointment		
Description (clear language)	Diagnosis Code (ICD-10 Code)	Service Code (CPT, HCPCS, DRG)	Quantity	Expected Cost
Primary service description here (P)				
Spinal Manipulation (R)		98941	1	$XX
Electric Stim (R)		G0283	5	$XX
Re-Evaluation		99213	1	$XXX
P - Primary Service (initial reason for visit) C – Co-provider services R - Reoccurring Services or item (valid for up to 12 months from date on this form)		Total Expected Charges	$	
		Date of Good Faith Estimate:		

Example of Medicare Advantage Good Faith Estimate

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NSA Good Faith Estimate

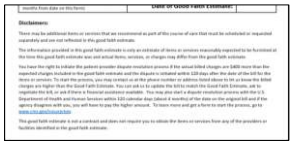
10.The GFE Disclaimers:

a) There may be addition unforeseen items or services.

b) This is only an estimate

c) You have the right to initiate a dispute resolution process if the actual billed charges are over $400 more than the estimated charges. This must be done within 120 days after the date of the bill. Includes information how to do this.

d) Disclaimer stating that this is NOT a contract.



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Patients Have Rights

The Patient has the right to file a Complaint

- If the patient receives a bill that is at least $400 more than the total expected charges for that provider or facility on the good faith estimate, there is a new federal patient-provider dispute resolution (PPDR) process available under the No Surprises Act.
- The patient may request a payment review and decision from an independent company certified by the federal Department of Health and Human Services. These companies are referred to as Selected Dispute Resolution (SDR) entities.
- The SDR entity will decide what amount the patient must pay if the bill is at least $400 more for any provider or facility.

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NSA Good Faith Estimate

- The GFE is valid for *up* to12 months from the date on the form.
- The GFE is good for recurring services or items
- The GFE is part of the MEDICAL RECORD.
- Keep a copy in the patient's chart via statutes set forth in your state law.

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Required Compliance Documents

Update Your Financial Policies in Your Compliance Manuals

Manual Resources at www.AskMario.com

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- The Railroad Retirement Board (RRB) is also mailing new Medicare cards with the MBI.
- The RRB logo will be in the upper left corner and "Railroad Retirement Board" at the bottom

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Verify Identity

The Medicare Card
- Name
- Medicare Number
- Effective date of entitlement

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Medicare Beneficiary Identifier (MBI)

- MBIs are numbers and upper-case letters. We'll use numbers 0-9 and all letters from A to Z, except for S, L, O, I, B, and Z. This will help the characters be easier to read.
- The MBI will contain letters and numbers. Here's an example:

1EG4-TE5-MK73

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Medigap PLAN F

- Both Part A and Part B deductibles are covered by the plan
- Best if you've got serious or chronic health conditions and have a lot of medical expenses each year.
- Phased out unless previously owned

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Medigap PLAN G

- Same coverage as Plan F except for the Part B deductible, which is $240
- Part F and G are the only Medicare Supplement Plans that offer coverage for Part B excess charges
- There are no plans to phase out Plan G

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Medigap PLAN N

- No coverage for Part B deductible
- No coverage for Part B excess charges
- You may have a copay of up to $20 for doctor visits and $50 for hospital visits that don't result in admission.
- You must collect the co-pay each visit

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Medicare Part B (Original Medicare)
- Medigap
  - Plan F
  - Plan G
  - Plan N

Medicare Advantage (Part C)

130

Medicare Advantage Plans (Part C) are offered by *private* companies approved by Medicare. This is a Part B *replacement* plan.

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MEDICARE ADVANTAGE

Medicare Part B	Medicare Part C
• Part B helps pay for spinal manipulation. • The treatment must be deemed medically necessary by a medical professional to correct a subluxation (a condition when the vertebrae are out of position) by a chiropractor or other qualified provider. • **Medicare** will only cover manual manipulation, not other services offered at a chiropractor, such as X-rays, acupuncture or massage. • Other services or tests, including X-rays, are not covered	• Part C, also called Medicare Advantage, are Medicare plans offered by private insurance companies. Some Medicare Advantage plans may cover chiropractic treatments, but the terms can be different for each individual. • A Medicare Advantage plan may cover some or all of the costs, but plans can vary per person and provider.

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MEDICARE ADVANTAGE

- Medicare Advantage plans must cover at least the same chiropractic services as original Medicare, but copayments and deductibles may vary. The representative typically quotes benefits with the disclaimer that there is no guarantee of benefits.
- Medicare Advantage may require the patient to use an in-network provider.
- It Is a PRIVATE CONTRACT.

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UHC Medicare Advantage Plan

- In most Part C plans, as long as you are a provider for Medicare, you are in their program.
- Plans must cover all medically necessary services and supplies that Original Medicare covers. However, the representative typically quotes benefits with the disclaimer that there is no guarantee of benefits.
- **Specific plans within the Part C Medicare Advantage plans may cover maintenance care.** Plans such as AARP® Medicare Advantage, UnitedHealthcare® Dual Complete, and UnitedHealthcare® Group Medicare Advantage may cover maintenance spinal manipulation. There may be additional UnitedHealthcare plans as well that have this benefit. Since Medicare Advantage plans are private contracts within the Medicare system, the benefits must be verified before services are rendered.

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UHC Medicare Advantage Plan

- When the provider verifies benefits for any UnitedHealthcare Medicare member, **they must ask the representative if the member has the "*routine benefit*," and if so, how many routine visits are covered.** If the member has these benefits, they are there to utilize when the care is not deemed active treatment by the Medicare definition.
- Essentially, these plans have a benefit that allows for a certain number of visits for non-active treatment.

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Some UHC Part C Plans

98941 AT

98941

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Part C Benefit Questions to Ask

1. Do you follow the Medicare fee schedule?
2. Do you cover services other than spinal manipulation *in a chiropractic office?*
3. Do you accept the AT modifier?
4. Use GFE or other forms.

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Medicare (Part B) Modifiers

MODIFIER	INDICATION
GY	Used when an item or service is statutorily not covered. Do not use on CMT.
GP	Services delivered under an outpatient physical therapy plan of care.
GPGY	Used on physical therapy services in Medicare .
GZ	Used on CMT codes, when you expect Medicare to deny the service, but you did not get an ABN.
GA	**Used on CMT codes, when you expect Medicare to deny the service, and you have a signed ABN on file.**
AT	Used on CMT codes (spinal) to indicate active care.
Q6	Locum tenen is performing the service

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Medicare Advantage (Part C) Modifiers

MODIFIER	INDICATION
25	Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service.
GP	Services delivered under an outpatient physical therapy plan of care.
AT	Used on CMT codes (spinal) to indicate active care.

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- **L3020** -- Foot insert, molded to patient model, longitudinal/metatarsal support, each Guideline: Prescription Custom Fabricated Foot insert, each, removable. **This type of device is fabricated from a three-dimensional model of the patient's own foot (e.g. cast, foam impression, or virtual true 3-D digital image). Use Modifier RT and Lt and bill separately per foot.**
- **L3030** -- Foot insert, removable, formed to patient foot, each Guideline: Prescription Custom Fabricated Foot insert, each, removable. This type of device is **formed directly to the patient's foot through the use of an external heat source**. The heat source should sufficiently and permanently alter the shape of the device, activating a resin, or other method by which the shape of the device is sufficiently and permanently altered in order to provide continuous contact with the unique characteristics of the plantar aspect of the patient's foot.
- Billing: L3020 Rt, L3020 Lt

FOOT LEVELERS

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Informed Consent

- State Controlled
- Prior to treating a patient, the doctor must provide adequate information concerning the **possible risks, benefits and alternatives** to a particular procedure.
- Doctors must properly and clearly communicate with their patients.
- If called into question, documentation of the communication is vital.
- A general informed consent is recommended.

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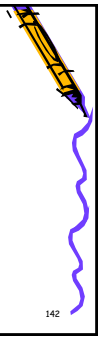
Informed Consent

- Describe the procedures to be employed.
- **Disclose the risks of treatment**
  - **Inherent – foreseeable**
- Answer any questions for the patient



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The Informed Consent

From a risk management perspective, there are two important elements in the informed consent process: (1) communication between the physician and the patient, with the physician giving the patient appropriate information so that the patient understands the options for care and can make an informed decision regarding treatment; and (2) appropriate documentation. Informed consent is not just obtaining a signature on a form.

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The Informed Consent

Key Points to Consider:

- All new and existing patients should complete the Informed Consent. Advise all existing patients that you are simply updating their information. (medical history, medications, supplements)
- Standardize your intake process.
- Obtain Informed Consent *before* services are rendered.
- Be open and informative with patients.
- Consult your malpractice carrier and state association.

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The Informed Consent

CMS also states that a properly executed informed consent form should be specific to the patient and should contain at a minimum:

- The name of the specific procedure or type of treatment for which consent is being given.
- The name of the responsible practitioner who will perform the procedure or administer the treatment.
- A statement that the procedure or treatment, including anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative.
- The signature of the patient or patient's legal representative.
- The date and time that the form is signed by the patient or patient's legal representative.

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The Informed Consent

- A "process" of informing the patient of the risks and benefits of care, so that they may make a decision and control their care.
- Many patients are new to chiropractic.
- Ideally presented over a course of consultation and report of findings.
- it gives you the opportunity to dispel misconceptions
- **Consultation** – what we are going to do in general
- **Report of Findings** – what we are going to do specifically

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The Informed Consent

- When to get the informed consent:
  - The new patient consultation AND report of findings PROCESS.
  - Established patient with a new area of complaint

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CLEAR COMMUNICATION of the Informed Consent

- Must be in plain language. If the average lay person cannot understand the terms used in the consent, a judge may throw the informed consent out.
- Must be separate from other documents. Do not mix it in with HIPAA notices and the Financial Policy. *"Shrouded Importance"*
- Must be addressed verbally with the patient to give them the opportunity to address questions
- Elicit engagement of the patient and family

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Components of the Informed Consent

- Without a consent form, charges may be levied that the touching was unwanted – sexual abuse.
- With an improper informed consent, it may be alleged that you caused injury and were guilty of neglect.

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The "Reasonable Standard" Law

- Physicians are held to a "reasonable standard."
- A doctor is required to tell a patient what another reasonable doctor would tell the patient under similar circumstances.

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Patients Must have The Mental Capacity to Decide

- The patient must realize that they have the ability and the right to make a decision.
- If a patient is unable to make decisions the legal designee needs to be identified. Policies and procedures must be made to assess the patient capacity and how to identify a legal designee.
- Is the patient able to make and communicate a choice?
- Is the patient able to understand key information about their condition, the treatment options, benefits, harms, and risks; and is not required by law or court order to undergo treatment.
- Does the minor have the right to consent?

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OFFICE NAME
Informed Consent

Please read this entire document prior to signing. Ask questions before you sign if there is anything that is unclear.

Based on my complaints and the history I have provided, I hereby authorize OFFICE NAME Health ("the Practice") and its licensed doctors and assistants [illegible] an examination and provide an evaluation and treatment plan [illegible] chiropractic adjustments and other tests and procedures consider[illegible] appropriate. I understand that state law entitles me to receive [illegible] treatment and refuse any treatment to [illegible] that knowledge and with my consent, I wish to rely on the OFFICE [illegible] make those decisions about my care based on the facts they believe [illegible] best interest.

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RISKS

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, [illegible]es, disk injuries, strokes, dislocations, sprains, and those that rel[illegible] aberr[illegible] unknown or reasonably undetectable by the doctor. [illegible] have been associated with injuries to th[illegible] to or [illegible] resulting to serious complications including stroke. So[illegible] stiffness and soreness following the first few days of treatment. [illegible] will make every reasonable effort during the examination to screen for contraindications to care; however, if I have a condition that would otherwise not come to the Doctor's attention, I understand that it is my responsibility to inform the Doctor before treatment.

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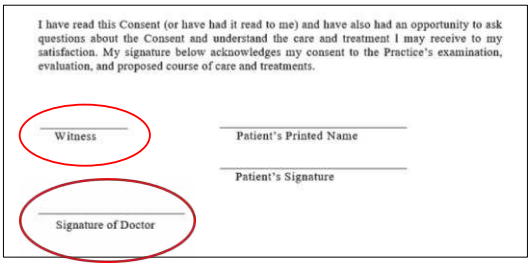
I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand the care and treatment I may receive to my satisfaction. My signature below acknowledges my consent to the Practice's examination, evaluation, and proposed course of care and treatments.

Witness

Patient's Printed Name

Patient's Signature

Signature of Doctor

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Special Circumstances Informed Consent

- Decompression Therapy
- Acupuncture
- Dry Needling
- Laser
- Shock wave
- If you don't take x-rays

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For Additional Information

- Contact your malpractice carrier.
- Contact UVCA
- Resource: *Be Informed about Chiropractic Informed Consent,* Chiropractic Economics, Mario Fucinari DC, CPCO, Sept. 7, 2022. https://www.chiroeco.com/chiropractic-informed-consent/

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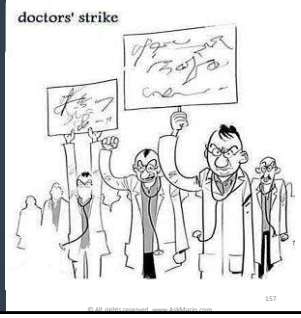
Notes Must Be Legible



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Virginia Board of Medicaine

"Practice of chiropractic" shall include

(i) requesting, receiving, and reviewing a patient's medical and physical history, including information related to past surgical and nonsurgical treatment of the patient and controlled substances prescribed to the patient, and

(ii) documenting in a patient's record information related to the condition and symptoms of the patient, the examination and evaluation of the patient made by the doctor of chiropractic, and treatment provided to the patient by the doctor of chiropractic.

Virginia Board of Medicine, Chapter 29, Article 1. General Provisions, § 54.1-2900. Definitions, page 9.

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Virginia Board of Medicaine

Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic, Virginia Board of Medicine.

18VAC85-20-26. Patient records.

A. Practitioners shall comply with provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.

B. Practitioners shall provide patient records to another practitioner or to the patient or the patient's personal representative in a timely manner in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.

C. Practitioners shall properly manage patient records and shall maintain timely, accurate, legible and complete patient records.

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159

Virginia Board of Medicaine

Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic, Virginia Board of Medicine.

18VAC85-20-26. Patient records.

D. Practitioners shall maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

1. **Records of a minor child, including immunizations, shall be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child; or**
2. **Records that have previously been transferred to another practitioner or health care provider or provided to the patient or the patient's personal representative; or**
3. **Records that are required by contractual obligation or federal law to be maintained for a longer period of time.**

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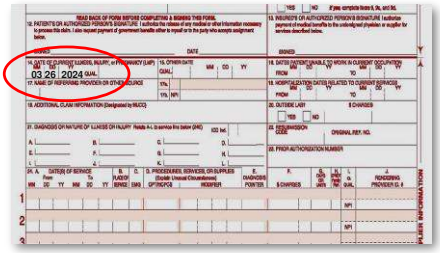

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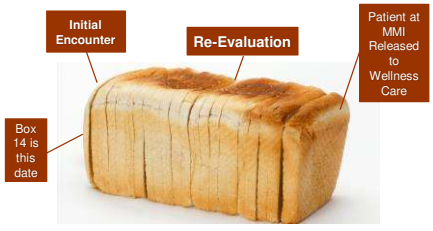

EPISODE OF CARE

162

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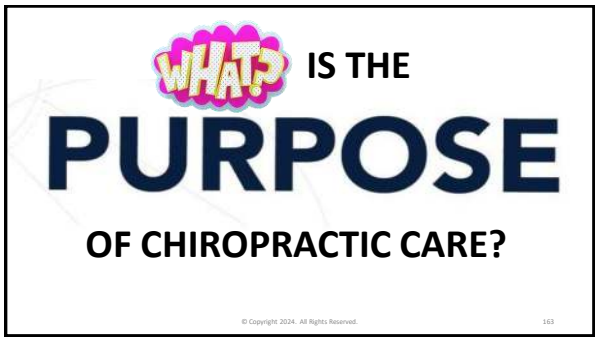

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Title XVII of the Social Security Act, Section 1862 [a][1][a]

"Medicare may only pay for items or services that are "reasonable and necessary" for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member."

www.ssa.gov/OP_Home/ssact/title18/1862.htm

FOOT LEVELERS

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BCBS Chiropractic Services Policy

FOOT LEVELERS

goals and outcome measures for a new problem or a problem re-assessment. **(Plan)**

- A written plan of treatment relating to the type, amount, frequency, and duration of care is required for all patients. The plan of care must be updated as the patient's condition changes. A treatment plan is not valid for longer than 90 calendar days from the first treatment day under the certified treatment plan. The goal of the treatment plan should be to achieve functional improvements in the patient's condition. Specific treatment goals must be documented with anticipated time frames and objective measures to evaluate treatment effectiveness. Each complaint should be listed with selected treatment, duration, frequency, treatment goals, and objective measures to evaluate progress. The treatment plan should include the rationale for all services provided. A plan of care should be individualized for each patient. Documentation must support that each manipulation or treatment reported relates to a relevant symptomatic spinal and/or extraspinal region. Symptoms must bear a direct relationship to the level of subluxation cited. Documentation of "pain" is not sufficient; the location of pain or condition must be described. **(Plan of Care)**
- Signature requirements- Each medical record must be signed and dated by the clinician

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Medical Necessity

OATS

1. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services must have a direct therapeutic relationship to the patient's condi (Medicare does not pay for pain).

Treatment Goals

2. You must have a reasonable expectation of recovery or improvement of function.

P.A.R.T.

3. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam. A diagnosis of pain is not sufficient for medical necessity

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Medicare Medical Necessity

- **Acute subluxation** - treatment for a new injury, identified by x-ray or physical exam. The treatment is expected to improve, arrest, or retard the patient's condition.
- **Chronic subluxation** - A patient's condition is considered chronic when it is not expected to completely resolve (as is the case with an acute condition), **but where the continued therapy can be expected to result in some functional improvement. Once the functional status has remained stable for a given condition, further manipulative treatment is considered maintenance therapy and is not covered**.

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Medical Necessity

Acute exacerbation is a temporary but marked deterioration of the patient's condition that is causing significant interference with **activities of daily living** due to an acute flare-up of the previously treated condition. The patient's clinical record must specify the date of occurrence, nature of the onset, or other pertinent factors that would support the medical necessity of treatment. As with an acute injury, treatment should result in improvement or arrest of the deterioration within a reasonable period of time.

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Medical Necessity

Maintenance Therapy

- **Once MMI has been reached, Medicare will NOT pay for maintenance or supportive care.**
  - 1. Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or 2. maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

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The *FUNCTIONAL* Consultation

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During the initial evaluation, describe the patient's presenting condition (symptoms, physical signs, and function) in **objective, measurable terms** along with pertinent subjective information. Provide a clear description of the mechanism of injury and **how it negatively impacts baseline function**. A clear plan of treatment should include treatment goals, expected duration and frequency, and the **clinical milestones** to be used as measures of progress.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-MLN9130552.pdf

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The Universal Initial Report

- Status of the patient
  - New : Never seen before or not in the last three years
  - Established: Patient seen by you or other doctors in your group of the same specialty, within the last three years
- Chief Complaint (cc)
- PFSH – Past, Family, Social History
- Review of Systems (ROS)
- HPI: L, M, N, O, P, Q, R, S, T
- Dx
- Treatment Plan
- Signature

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Medicare Initial Encounter Report

Symptoms causing patient to seek treatment

Family History

Past Health history

Mechanism of Trauma

Quality and character of symptoms/problem

Onset, duration, intensity, frequency, location and radiation

Provoking and Palliative Factors

Prior interventions, treatments, medications, secondary complaints

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Medicare Initial Encounter Report

- **Q**uality and character of symptoms/problem
- **R**adiation of symptoms
- **S**everity
- **T**ime

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Medicare Initial Encounter Report

Treatment Plan

- Recommended Level of Care
  - Duration and frequency of visits
- Specific Treatment Goals
  - What are you trying to accomplish?
- ***Objective*** measures to evaluate treatment effectiveness
  - How do you know when the treatment has been accomplished?

Date of Initial Treatment (Box 14)

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Treatment Goals *Must* Address ***Function***

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Evidence Based
Outcomes Assessment Tools (OATs)

"Functional Impairment Rating"

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Why Outcomes Assessment?

- An ***objective*** measure of the patient's **ADL** status
- Provides ***objective*** documentation regarding the patient's condition.
- Helps the doctor, patient and insurer to make *informed* decisions
- A deterrent to malpractice
- Backed up by refereed journals (JMPT, Spine)

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Revised Oswestry

Functional Disability Score

0-5% = None
6-20% = Mild
20-40% = Moderate
40-60% = Severe
60-80% = Crippled
80%+ Bed Bound


Revised OSWESTRY Low Back Pain Disability Questionnaire

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Neck Pain Disability Index Score

0-8 = None
10-28% = Mild
30-48% = Moderate
50-68% = Severe
>70% = Crippled


NECK PAIN DISABILITY INDEX QUESTIONNAIRE

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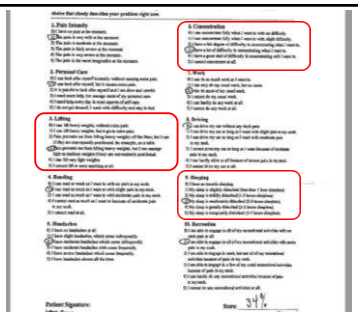
Neck Pain Disability Index



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OATS ⟶ Tx Goals

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Outcome Assessment Tests (OATs)

To be significant, the outcome assessment test must have a minimum reduction of a 30% in score between the initial exam and the re-exam to be clinically significant.

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General Treatment Goals

As time progresses, the short term goals progress until finally they catch up with the long term goals.

Long – Term Wellness Goals →

ADL Rehab Goals →

Acute Pain Goals →

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Short – Term Goals (First 2-3 weeks)

1. **Decrease pain, spasms, edema and increase range of motion**
2. Resolution of any radicular pain in the lower extremity
3. Patient will be able to sleep in bed without pain for 6-8 hours.
4. Patient will be able to tie shoes without pain in 2 weeks
5. Independent with basic self-care ADL such as bathing without increased low back pain

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Long – Term Goals (4-6 weeks)

1. Low back pain at worst less than or equal to 4/10 with all activities
2. Patient will ambulate 15 minutes at 2.0 miles per hour without increased low back pain
3. Bilateral hip flexion, multifidus and gluteal strength from 4+ to 5/5
4. Patient will be able to stand for 20 minutes or longer without pain in 4 weeks
5. Patient will demonstrate an improvement on their OATS score of >30% in 4 weeks
6. **To prepare the patient for a home-based exercise program**

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UNIVERSAL SOAP NOTE TEMPLATE

Subjective
- Give chief complaint(s) as described by the patient that day.
- Give pain levels for each region being treated.
- Describe any functional improvement. This goes to reaching the treatment goals.

Objective
- Give all palpatory findings
- Repeat orthopedic and neurologic tests if applicable

Assessment
- The assessment shows the medical necessity for care. It is comparable to Medical Decision Making. You want to indicate how the patient is improved and why they still need care. *Example: The patient is improved with decreased arm pain and decreased edema, but still has subluxation and spasms at C7.*

Plan
- Document the segments adjusted, the technique used, and the patient's reaction to treatment. *Example: CMT C1, T3, T7, L5, and Right SI Diversified, Patient tolerated treatment without incident.* This is very important for risk management.

Signature: Either hand sign or electronic signature. Should have name of provider and credentials. Preferred to have time and date stamp.

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E/M Guidelines 2024

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Selecting the Appropriate Level of E/M

Medical Decision Making (MDM)
- Number and complexity of problems addressed
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

OR

Time
- Total time (face-to-face and non-face-to-face)

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MDM and the NEW Guidelines

Medical Decision Making is defined as the process of establishing diagnoses, assessing the status of a condition, and/or selecting a management option.

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Use Technology to Reduce Time in the Office

- *Clerical staff* updates their insurance information
- Consider using telephone or video to pre-screen patients
- Schedule the patient for their *virtual* consultation appointment
- *Clinical staff* records the patient's chief complaint(s),history, new injuries, flare-ups, surgeries, medications, loss of function.
- Clinical staff alerts the Clerical staff to obtain past records
- Any work the clinical staff does, the doctor reviews the information **on the day of the examination appointment. That information gained goes into the Medical Decision Making (MDM) element.**

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Two of the three elements must be met to determine the code

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Me		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test	Low risk of morbidity from additional diagnostic testing or treatment

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Level of MDM (Based on 2 out of the 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
Low 99203 99213	Low ▪ 2 or more self-limited or minor problems; ▪ 1 stable, chronic illness; ▪ 1 acute, uncomplicated illness or injury; ▪ 1 stable, acute illness; ▪ 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (1 out of 2 categories) Category 1: Tests and documents ▪ Any combination of 2 from the following: ▪ Review of prior external note(s) from each unique source*; ▪ Review of the result(s) of each unique test*; ▪ Ordering of each unique test* Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment

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99204/99214 MDM

Level of MDM (Based on 2 out of the 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
Moderate **99204** **99214**	Moderate ▪ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; ▪ 2 or more stable, chronic illnesses; ▪ 1 undiagnosed new problem with uncertain prognosis; ▪ 1 acute illness with systemic symptoms; ▪ 1 acute, complicated injury	Moderate (1 out of 3 categories) Category 1: Tests and documents ▪ Any combination of 3 from the following: ▪ Review of prior external note(s) from each unique source*; ▪ Review of the result(s) of each unique test*; ▪ Ordering of each unique test* ▪ Assessment requiring an independent historian(s) Category 2: Independent interpretation of tests Category 3: Discussion of management or test interpretation	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: ▪ Prescription drug management ▪ Decision regarding minor surgery with identified patient or procedure risk factors ▪ Decision regarding elective major surgery without identified patient or procedure risk factors ▪ Diagnosis or treatment significantly limited by social determinants of health

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NEW 2024 Time Calculations

ONLY FOR OUTPATIENT SERVICES

CODE	TIME in Minutes
99201	Code Deleted
99202	Must meet or exceed 15
99203	Meet or exceed 30
99204	Meet or exceed 45
99205	Meet or exceed 60
99211	Time Removed
99212	Meet or exceed 10
99213	Meet or exceed 20
99214	Meet or exceed 30
99215	Meet or exceed 40

PRE-SERVICE + SERVICE + POST-SERVICE = *TOTAL* TIME

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Number and Complexity of Problems

- Lumbar Pain
- Right sacroiliac pain
- Hyperpronation syndrome – Q-angle – Kinetic chain Disruption
- Lumbar DDD

2 or more self-limited problems
1 chronic illness
Number and Complexity = Low = 99203/99213

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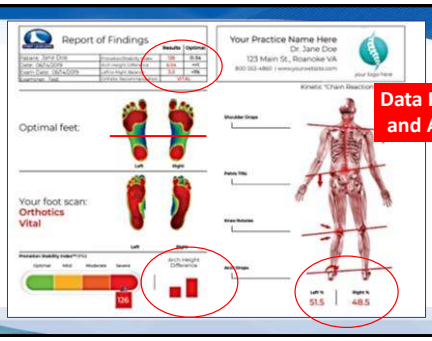

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Scan *Every* Patient

Make this your protocol

- Various studies show **overpronation creates biomechanical dysfunction**
- It's an educational opportunity to show patients **the feet play an instrumental part in the care you provide**

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TAKE THEIR ***COMPLETE*** VITALS

FOOT LEVELERS

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200

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NEW!

REQUIRED CORPORATE COMPLIANCE AND HIPAA MANUAL BUNDLE USE PROMO CODE BUNDLEIT FOR DISCOUNT PRICE ON CHECKOUT

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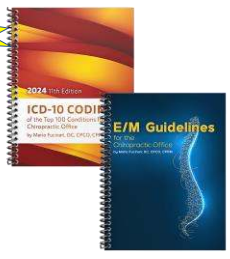
NEW!



E/M GUIDELINES AND ICD-10 2024 EDITION MANUAL BUNDLE USE PROMO CODE BUNDLEIT FOR DISCOUNT PRICE ON CHECKOUT

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If you have questions…

- www.FootLevelers.com
- www.Askmario.com
- ICD10 Coding Book and Manuals at www.Askmario.com
- E-mail: Doc@AskMario.com

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