Medicare Coding and Billing
Part 2

Sequestration

- As of now there are no changes in Sequestration.
- The Medicare Fee Schedule will change April 1.
- If you are a non-par doctor, check your MAC website for the current fee schedule.
- Pay particular attention to the Limiting Charge.

Revalidation

- Medicare is starting a new round of Revalidation.
- Anyone enrolled in Medicare before March 2011 will be revalidated.
- CMS expects to finish by March 2015.
- You have 60 days after receiving a request for revalidation to submit the required materials or you will be removed from Medicare enrollment.
- There may be fees involved this time.
- Indications are that you will be assigned a risk rating.
- Also, indications are that they will be looking at compliance programs this time.

Comparative Billing Reports

- If you received Comparative Billing Report in the first round you should be receiving another one soon.
- This one will compare your 2011 levels of service with services from 2009 that were reported in the 2010 report.
- Remember that the 2010 reports went to the top 5000 chiropractic utilizers of Medicare.

Importance of PQRS

- If you have not yet started to report the PQRS measures, I urge you to do so ASAP.
- The future of Medicare will be to pay for the condition, not for the services provided.
- The results from the PQRS measures will be used to determine the time required to resolve various conditions.

CMS 1500 Form

- **Item 14 -** Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19. Reminder: For date fields other

than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). **Intermixing the two formats on the claim is not allowed. Item 15 -** Leave blank. Not required by Medicare. **Item 16 -** If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work.

- An entry in this field may indicate employment related insurance coverage.**Item 17 -** Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data.
- When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.
- The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to: 5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). 1861(s) The term "medical and other health services" means any of the following items or services:
- physicians' services;
- (2)(A) services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills (or would have been so included but for the application of section 1847B);**Referring physician** - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program. **Ordering physician** - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.
- Chiropractors can only order or refer for services directly related to manual manipulation to the spine to correct subluxation.
- For all other services you must send the patient back to their MD or DO for evaluation.**Referral**: Turning the patient's care over to another doctor.
- **Request for Consult**: Requesting another doctor evaluate the patient and render an opinion and return the patient to you for continued care.**Item 17a** – Leave blank.
- **Item 17b Form CMS-1500 –** Enter the NPI of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data. **Item 18 -** Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as

a result of, or subsequent to, a related hospitalization. **Item 19** - Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, is on file, along with the appropriate x-ray and all are available for carrier review.**Item 20 -** Complete this item when billing for diagnostic tests subject to the anti-markup payment limitation.

- Chiropractors will not use this box**Item 21 -** Enter the patient's diagnosis /condition. All physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order.
- **Item 22 -** Leave blank. Not required by Medicare.**Item 23 -** Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval. **Item 24 -** The six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service. **Item 24A -** Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. **Item 24B -** Enter the appropriate place of service code(s) from the list provided in section 10.5. Identify the location, using a place of service code, for each item used or service performed. This is a required field. 11 Office
    - 12 Home
    - 21 Inpatient Hospital
    - 22 Outpatient Hospital
    - 23 Emergency Room-Hospital
    - 26 Military Treatment Facility
    - 31 Skilled Nursing Facility **Item 24C -** Medicare providers are not required to complete this item. **Item 24D -** Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code.
- When applicable, show HCPCS code modifiers with the HCPCS code.
- The Form CMS-1500 has the ability to capture up to four modifiers.
- Enter the specific procedure code without a narrative description.
- This is a required field. **Item 24E -** Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item.
- When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4.
- This is a required field.
- If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21. **Item 24F-** Enter the charge for each listed service. **Item 24G -** Enter the number of days or units.

- If only one service is performed, the numeral 1 must be entered.**Item 24H** - Leave blank. Not required by Medicare. **Item 24I -** Enter the ID qualifier 1C in the shaded portion. **Item 24J -** Enter the rendering provider's NPI number in the lower unshaded portion. **Item 25 -** Enter the provider of service or supplier Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate check box.
- Reimbursement of claims submitted without tax identification information will/may be delayed. **Item 26 -** Enter the patient's account number assigned by the provider's of service or supplier's accounting system.
- This field is optional to assist the provider in patient identification. **Item 27 -** Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. **Item 28 -** Enter total charges for the services (i.e., total of all charges in item 24f). **Item 30 -** Leave blank. Not required by Medicare.
- **Item 31 -** Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 1998) the form was signed.
  - **NOTE:** This is a required field, however the claim can be processed if the following is true.
  - If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or
  - If any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS(I certify that the statements on the reverse apply to this bill and are made a part thereof.) **Item 32** – Effective January 1, 2011, for

  claims processed on or after January 1, 2011, submission of the location where the service was rendered will be required for all POS codes. **Item 32a -** If required by Medicare claims processing policy, enter the NPI of the service facility.
- **Item 32b -** Effective May 23, 2008, Item 32b is not to be reported. **Item 33 -** Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field.
- **Item 33a -** Enter the NPI of the billing provider or group. This is a required field.
- **Item 33b -** Effective May 23, 2008, Item 33b is not to be reported.

The Back of the CMS 1500 Form

- Refer to the back of the CMS 1500 form.
- It contains notices to the physician and to the patient.BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.
- NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties**.**REFERS TO GOVERNMENT PROGRAMS ONLY

- MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. The next section is a statement about Black Lung.
- **SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)** I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS(I certify that the statements on the reverse apply to this bill and are made a part thereof.) This is how doctors fall prey to the False Claims Act.
- When you file a claim with the AT modifier and your records do not substantiate medical necessity, you have made a false statement to a government agency.No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).
- NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws. **NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION**
- This section is essentially a HIPAA notice to patients about how their information will be collected and used.**MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**
- This section relates directly to Medicaid claims.Completing the CMS 1500 form is key to getting paid, but it also requires attention to detail to avoid reviews and other difficulties.