Medicare Coding and Billing Part 2

By
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Section 514 of the SGR Repeal Act

- Last month I talked about Section 514 of the Sustainable Growth Rate Repeal Act that contained specific information regarding chiropractic.
- I have since prepared a detailed analysis of this section discussing how it will effect chiropractors.
- A link to this report is in my monthly update that my subscribers received Monday.
- Those of you that are not subscribers can receive this report by subscribing to my mailing list.
- **Action Steps:**
    - Get your Medicare documentation and procedures in order NOW. The best way to do this is to use my Medicare Documentation System available through the ChiroCode store.
    - If you are a member of the ACA, call them and let them know your opinion about how this should be handled.
    - If you are not a member of the ACA – join today.

Coventry Medicare Advantage

- Coventry is sending out notices that participating doctors must attest that they have complied with the "2015 CMS-Mandated compliance requirements".
- Those requirements include;
    - General compliance and fraud, waste, and abuse training.
    - Code of Conduct/compliance policies dissemination.
    - Exclusion list screenings.
    - Reporting mechanisms for potential fraud, waste, and abuse and compliance issues.
    - Offshore protected health information operation reporting.
    - Downstream entity oversight.
- These are the elements of an office compliance program.
- If you do not have a compliance program in place and operating in your office, you need one.

Completing the CMS 1500

- **Item 14** - Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date.
- Although this version of the form includes space for a qualifier, Medicare does not use this information; do not enter a qualifier in item 14.
- 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, ordering, or supervising physician if the service or item was ordered or referred by a physician.

- There are new qualifiers for physicians in box 17.
    - DN = Referring
    - DK = Ordering
    - DQ = Supervising
- 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:
    - (1) 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 twelve diagnoses in priority order.
- The "ICD Indicator" identifies the ICD code set being reported. Enter the applicable ICD indicator according to the following:
    - 9 = ICD – 9 – CM
    - 0 = ICD – 10 – CM
- Do not report both ICD-9 and ICD-10 on the same form.
- **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.
- The following are commonly use palce of service codes:
    - 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 letter as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis.
- Enter only one reference letter per line item.
- When multiple services are performed, enter the primary reference letter for each service.
- 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 29 -** Enter the total amount the patient paid on the covered services only.
- **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.
- This back of the CMS 1500 form has not changed.
- It contains notices to the physician and to the patient.
- When you sign the CMS 1500 form, this is still what you are agreeing to.
- 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.)
- Note this phrase carefully:

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. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

- Also note these phrases:

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.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

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.

- 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.
- Completing the CMS 1500 form is key to getting paid, but it also requires attention to detail to avoid reviews and other difficulties.