Medicare Fees
By
Dr. Ron Short, DC, MCS-P, CPC

ICD-10
- ICD-10 deadline is October 1.
- The following is taken from an AAPC alert from last week:
  - “Members of the House of Representatives' Energy & Commerce Sub Committee on Health expressed support for the Oct. 1, 2015 ICD-10 implementation, and urged fellow lawmakers to forego any further delays.”
- ICD-10 is going to happen this year.
- Because of the uncertainty with some third party payers, I would recommend that you start now to build up a cash reserve.
- If a (or several) third party payers are not ready on October 1, you will have the cash to operate with until the bugs are worked out.

Sustainable Growth Rate Formula Adjustment
- Congress has given itself until April 1 to repeal the Sustainable Growth Rate Formula (SGR).
- After April 1 a 21% cut is scheduled to be applied to the Medicare Physicians Fee Schedule.
- Everyone agrees that the SGR needs to go.
- Nobody knows how to pay for it.

Medicare Fees
- Medicare fees are based on a formula.
- \[\text{Medicare Fees} = [(\text{Work RVU} * \text{Work GPCI}) + (\text{Transitioned Non-Facility PE RVU} * \text{PE GPCI}) + (\text{MP RVU} * \text{MP GPCI})] * \text{Conversion Factor (CF)}\]
- The fees are broken down into categories;
  - Participating Amount
  - Non-Participating Amount
  - Limiting Charge
  - Various penalty Limiting Charges
- Each of these categories is then divided into a facility fee and a non-facility fee.
- The non-facility fee is what you charge when you are performing a service in your office.
- The facility fee is what you charge when you are performing a service in a facility such as a hospital or a skilled nursing facility (SNF).
- The # sign beside the row means that this is the facility fee.
- Some charges, such as x-ray, have modifiers which help determine the correct fee.
  - Modifier TC means “Technical Component” and is the fee charged for actually taking the x-ray.
  - Modifier 26 means “Professional Component” and is the fee charged for reading the x-ray.
  - When there is no modifier beside the code this means that this is the global fee and is the fee charged when you both take the x-ray and read it.
Medicare Physician Fee Schedule

- The Medicare Physician Fee Schedule is specific for each state.
- Some states are divided into geographic areas that each have a little different fee.
- Look up your fee schedule on your local Medicare Administrative Contractor’s website.

Facility vs. Non-Facility Fee

- The row with the # has the facility fee.
- The facility fee is lower than the non-facility fee because Medicare does not take into consideration the cost of your rent and utilities in calculating the fee.
- Use this fee when providing services in a hospital or SNF.

- The non-facility fee is the fee that you charge when billing for services provided in your office.
- This fee is calculated to include your rent and utilities.

Par Amount vs. Non-Par Amount

- Being a Participating Provider in Medicare means that you have signed an agreement with Medicare to accept assignment on all Medicare claims for the entire year.
- Being a Non-Participating Provider means that you have no such agreement.
- Being a Non-Participating Provider does not give you any special protections.
- You still have to comply with all of the laws, rules, and regulations of Medicare.
- You can still be audited, reviewed, and required to refund money.

- The Par Amount is the amount that Medicare approves.
- They will you pay 80% of this amount.
- Par Providers can bill their usual and customary fee to Medicare and they will reduce it to the Par Amount.
- The Non-Par Amount is 95% of the Par Amount.
- This is the amount that Medicare will approve and pay 80% of.
- The maximum amount that Non-Par Providers are limited to billing is the Limiting Charge.
Limiting Charge
- The Limiting Charge is the **maximum** amount that a Non-Participating doctor can charge a Medicare beneficiary.
- The Limiting Charge is 115% of the Non-Par Amount.
- You can round the Limiting Charge to the nearest dollar if you do so consistently.

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<thead>
<tr>
<th>NOTE</th>
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<th>NON-PAR AMOUNT</th>
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Penalty Limiting Charges
- When you fail to participate in certain Medicare programs, Medicare will “adjust” (cut) your fees.
- These programs are:
  - Physician Quality Reporting System (PQRS)
  - Electronic Health Records (EHR)
  - Electronic Prescribing (eRx)
- Participating Providers will automatically have their Allowed Amounts adjusted by Medicare.
- Doctors will receive a letter at the first of the year telling them what they did not participate in and what their fees will be for the next year.
- Non-Participating Providers have a special Limiting Charge, depending on which programs were participated in by the doctor.

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<th>PQRS LIMITING CHARGE***</th>
<th>EHR/2014 eRx LIMITING CHARGE**</th>
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- If you are a Non-Participating Provider and you did not attest for meaningful use of Electronic Health Records, this is the Limiting Charge that you use when billing Medicare patients.

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• Neither of the highlighted columns applies to chiropractors.
• They both involve failure to use E-Prescribing properly.
• Chiropractors are exempt from E-Prescribing.

Covered Services vs. Non-Covered Services

• The Medicare Physician’s Fee Schedule (MPFS) only applies to covered services.
• The only Medicare covered service for a chiropractor is the adjustment. (CPT codes 98940, 98941, and 98942)
• All other services are considered to be statutorily non-covered for Medicare.
• Also, the MPFS does not apply after the patient is given an ABN (unless Medicare goes ahead and pays the claim).
• How do you handle statutorily non-covered services?
• Some offices do not charge Medicare patients for anything other than the adjustment.
• Some offices offer discounts ranging from mild (5% to 15%) to very deep (50% to 90%).
• Some offices place these charges on the patient’s bill, never make any effort to collect, and then write off the charges.
• **All of these procedures are wrong!**
• When you offer free or discounted services to a Medicare beneficiary, you could be violating:
  o The Inducements Law
  o The Anti-Kickback Law
  o The False Claims Act
• Violation of any of these laws could result in a fine of $10,000 per occurrence and/or potential jail time.
• These procedures are usually motivated by a desire to help people that are on a tight budget to get the care that they need.
• The safe and legal way to do this is with a Discount Medical Plan Organization (DPMO)
• The DPMO that I recommend is ChiroHealth USA.
ChiroHealth USA

- **What makes DMPOs legal?**
  - Operate in every state, regulated by the DOI in varying degrees in over 34 states.
  - Most are owned and operated by major insurance carriers:
    - Cigna
    - Aetna
    - BCBS
    - UHC/SAM’s Club
  - ChiroHealth USA is a privately owned network
  - Contract with Alliance HealthCard of FL
  - Patients join the Plan in the doctors’ office when covering financial arrangements and policy.
  - $49.00 year, which covers the patient and their legal dependents.
  - Typically save the fee on the 1st visit
  - Using a DMPO allows you to establish a simple summary of your office financial policy
  - Minimize likelihood of triggering a complaint related to DFS, TOS, Inducement, AKB and FCA Violations
  - Allows you document, code, bill, collect and discount correctly
    - No more up coding, down coding based on payer type
    - No more fees based on payer type
    - No more “Let’s Make a Deal” at the front desk

- **How are the Discounts determined?**
  - DMPO discounts vary by network and providers and can range from 5% to 50% or more depending on the service.
  - In CHUSA, doctors set their own level of discounts which may be a simple percentage off UCR, as well as, a capped fee for their New Patients and Routine office visits.
  - This is not a “global fee”, but a capped fee, which again encourages doctors to document, code correctly, bill correctly and discount correctly using a “contractual network discount”.

- **What is the cost for me to join?**
  - No cost for the doctor

- **Can my contract be sold?**
  - Contract only allows us to contract with a DMPO
  - No provision to contract with other entities
  - No chance of Silent PPO activity
  - 30-day opt out clause

- **Common problems solved by using ChiroHealthUSA…**
  - Leaving revenue on the table
  - Converting shopper calls to NP
  - Transitioning from insurance to private payment
  - Encouraging those with limited benefits like Medicare to accept services, therapy or rehab
  - Dealing with high deductible or copay plans
  - Competing with out of network plans

- **Two of the main reasons that I recommend ChiroHealth USA is that;**
1. You set your own discount rate.
2. The doctor that designed this program is an MCS-P.

Check Your Risk Rating
- ChiroHealth USA is offering a free Risk Assessment Score to determine if your current practices are placing you and your practice at risk.
- Go to www.mychirosis.com.
- Complete the on-line form.
- You will receive a Risk Assessment Score in 1-2 days.
- If you are at high risk, you should give some serious consideration to putting an Office Compliance Program in place.
- You can receive more information regarding the Office Compliance Program by contacting me at chiromedicare@gmail.com.

Summary
- Fees for covered services are set by Medicare when the care is medically necessary.
- For services that are not covered and for care that is not medically necessary, you can charge your usual and customary fees.
- Discounting those fees in a non-compliant manner could put you and your practice in danger.