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.
- [(Work RVU * Work GPCI) +
  (Transitioned Non-Facility PE RVU * PE GPCI) +
  (MP RVU * MP GPCI)] * 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.

NOTE	PROCEDURE	MOD	PAR AMOUNT
#	98941		33.64
	98942		50.80
#	98942		45.34

- 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.

NOTE	PROCEDURE	MOD	PAR AMOUNT
#	98941		33.64
	98942		50.80
#	98942		45.34

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.

NOTE	PROCEDURE	MOD	PAR AMOUNT	NON-PAR AMOUNT
#	98941		33.64	31.96
	98942		50.80	48.26
#	98942		45.34	43.07

NOTE	PROCEDURE	MOD	PAR AMOUNT	NON-PAR AMOUNT
#	98941		33.64	31.96
	98942		50.80	48.26
#	98942		45.34	43.07

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.

NOTE	PROCEDURE	MOD	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE
#	98941		33.64	31.96	36.75
	98942		50.80	48.26	55.50
#	98942		45.34	43.07	49.53

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.

NOTE	PROCEDURE	MOD	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	EHR LIMITING CHARGE**	PQRS LIMITING CHARGE***	EHR/2014 eRx LIMITING CHARGE**	EHR + PQRS LIMITING CHARGE****	EHR/2014 eRx + PQRS CHARGE****
#	98941		33.64	31.96	36.75	36.39	36.20	36.02	35.85	35.48
	98942		50.80	48.26	55.50	54.95	54.67	54.38	54.12	53.57
#	98942		45.34	43.07	49.53	49.04	48.78	48.54	48.30	47.82

- 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.

EHR LIMITING CHARGE**
36.39
54.95
49.04

- If you are a Non-Participating Provider and you did not participate in the Physician Quality Reporting System, this is the Limiting Charge that you use when billing Medicare patients.

PQRS LIMITING CHARGE***
36.20
54.67
48.78

- If you are a Non-Participating Provider and you did not participate in the Physician Quality Reporting System or attest for meaningful use of Electronic Health Records, this is the Limiting Charge that you use when billing Medicare patients.

EHR + PQRS LIMITING CHARGE****
35.85
54.12
48.30

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

EHR/2014 eRx LIMITING CHARGE**	EHR + PQRS LIMITING CHARGE****	EHR/2014 eRx + PQRS CHARGE****
36.02	35.85	35.48
54.38	54.12	53.57
48.54	48.30	47.82

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:
    - The Inducements Law
    - The Anti-Kickback Law
    - 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.mychiroras.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.