The Medicare Edition

Medicare's recent updates to how they process claims have caused some confusion about how to submit a clean claim and how to respond to rejected claims. I thought an entire Back Channel Newsletter dedicated to your Medicare questions and concerns was in order! So, let's dive in!

When do I use an Advanced Beneficiary Notice (ABN)?

- ABN – implemented when billing to Original Medicare Fee For Service (FFS) beneficiaries, which includes Traditional Medicare and Railroad Medicare, but not Medicare Advantage plans.
- Must be updated whenever the reason for the expected non-coverage changes or at least yearly even without a change.
    - Issue an ABN:
        - For statutorily excluded or does not meet the definition of any Medicare benefit (optional but strongly encouraged)
        - Exceeds frequency guidelines
        - May be considered supportive or maintenance care
        - May not be considered reasonable and necessary
        - The claim does not include a subluxation diagnosis code
        - Services are not covered for the diagnosis code billed

How do I know which fee I am allowed to charge in the Medicare Fee Schedule?

- NJ is split into two separate fee schedules according to county. Find your county to determine which schedule of fees apply to you.
    - Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union, and Warren are all Locality Number 01
    - All other counties are Locality Number 99
- The Fee schedule is then further divided between provider participating status and assignment of benefits.
    - When a provider enrolls in Medicare, they can choose to be participating or non-participating.
        - Participating providers accept assignment and agree to the Participating Fee
        - Non-participating providers can decide on a claim-by-claim or patient-by-patient basis whether to accept assignment.
            - If a provider accepts assignment, Medicare will pay 80% of the non-participating fee schedule and the provider may only charge the patient the deductible and/or 20% of the Medicare non-participating fee schedule.
            - If they do not accept assignment, the provider may charge up to the Limiting charge, but not more than this amount.

Which modifier do I use and in which order?

Many of you have expressed concerns about when to use which modifier. Listed below are the modifiers for Medicare.

- **AT modifier:** Chiropractors must bill the AT modifier when reporting codes 98940, 98941, and 98942 to indicate active/corrective treatment. Claims submitted without the AT modifier will be denied for maintenance therapy.
    - If a provider has determined that a patient is no longer in active treatment and has entered into supportive or maintenance care, the AT modifier is not to be used. The proper ABN modifier is applied (see below).

        - ALERT!!! When a provider submits a claim without an AT modifier, Medicare will send the claim back to confirm the provider did not submit the claim without the AT modifier in error. The following scenarios will then apply:
            - Provider was mistaken, puts the AT modifier on the claim and resubmits.
            - Provider was correct, no error and no AT modifier to be added. Provider must wait 24 hours and resubmit claim. The claim will be accepted at that time and processed.
                - If a claim is submitted before 24 hours, it will be denied again as a duplicate claim
- **ABN Modifiers:**
    - **GA modifier:** Waiver of Liability Statement Issued, as required by Payer Policy. This modifier notifies Medicare that an ABN form was executed for covered services (CMT codes only)
    - **GX modifier:** Waiver of Liability Statement Issued, as voluntary by Payer Policy. This modifier notifies Medicare that an ABN form was executed for non-covered services. (All other services billed, except CMT)
    - **GY modifier:** Item or service statutorily excluded does not meet the definition of any Medicare benefit. For chiropractic services, this would include exams, x-rays, and physical medicine modalities and services.

- **Physical Medicine Modifier:**
    - **GP modifier:** Physical medicine codes require a GP modifier and ***must*** be the primary modifier before adding ABN modifier.

How do I know how many visits Medicare will cover? And when do I have the patient sign the ABN?

- The number of visits covered by Medicare is ultimately based on medical necessity. Medicare contractors may implement treatment parameters or review screens, but treatment limits (caps) are not permitted by CMS at this time for chiropractic care.

- If you can document in the records that there is a reasonable expectation of clinical improvement with continued chiropractic care and you are progressing toward the treatment plan goals, ongoing care may be warranted.

- If the patient is not showing progression toward the goals, then treatment may be considered maintenance or supportive care. If the patient wishes to continue with the treatment plan, fully knowledgeable, that services may not be reimbursed, an ABN should be issued.