Dynamic Chiropractic

BILLING & CODING

Clearing Up the Confusion: Medicare Billing for DCs

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Question: *I need a debate between a colleague and myself settled. Do I always have to bill Medicare at the Medicare-allowed rates or are there instances in which I may bill my regular rate to a Medicare patient?*

This is an interesting inquiry I have received a few times this year, which means we need to be sure the profession has the correct information. To that end, let's discuss how doctors of chiropractic interact with Medicare and also answer your question, to ensure there is absolutely no confusion.

Medicare Status and Fee Rates

Medicare requires that non-opt providers (doctors of chiropractic are in this category) register or enroll with Medicare. This can be as a "participating" provider or "non-participating" status. Do not confuse non-participating with opt-out or not being enrolled.

Participating providers for Medicare are limited to the "participating" or "par" fee and must accept the assignment. They get higher reimbursement for assigned claims.

Non-participating providers, however, have an option to not accept the assignment and may charge the patient the "limiting charge," which is the highest fee allowed by Medicare, at the time of the visit. This amount is 15 percent *higher* than the par fee. However, should a non-participating provider accept assignment, they are paid the lowest rate by Medicare (the "non-par" rate), which is 5 percent *below* the par rate.

In both instances – whether registered as participating or non-participating – the provider is obligated to bill Medicare. This is technically why a provider who chooses to not enroll with Medicare should *not* see a Medicare patient when a spinal CMT is performed, as Medicare requires billing of covered services and only enrolled providers may bill. (That is a whole other can of worms

I will not open in this article.)

Clearly, if you are accepting assignment on a substantial amount of claims, it is monetarily better to be participating. But if you have a practice in which patients understand and can afford to pay up-front or out of pocket, then being non-participating offers higher reimbursement. Note that a patient on a claim with no assignment, however, will be paid 80 percent of the non-par rate, not the limiting charge.

Charging for Non-Covered Services

Now, in reference to the original question, when the service is covered by Medicare, the Medicare rate will prevail. But what about the instances in which services are not covered by Medicare? Of course, for doctors of chiropractic this means all services except spinal manipulation: exams, X-rays, therapies, etc. These can be charged at your regular rate and are not limited to the Medicare fee schedule. This will also include spinal manipulation when it is not covered by Medicare, such as maintenance care or preventative care.

Medicare provides guidance directly on this issue. The *Medicare Claims Processing Manual*, specifically section 50.7.3, states the following:

A beneficiary who has been given a properly written and delivered Advanced Beneficiary Notice (ABN) and agrees to pay may be held liable. The charge may be the supplier/provider's usual and customary fee for that item or service and is not limited to the Medicare fee schedule. If the beneficiary does not receive proper notice when required, s/he is relieved from liability.

The above clearly indicates that for maintenance care or similar visit, when you provide an ABN the patient is liable for your regular rate and not the Medicare rate. However, the patient must be informed prior so when they choose to receive the care, they understand their specific liability for the service.

So, I am not sure who wins here, but indeed there can be some instances in which a Medicare patient can be liable for a fee beyond the Medicare rate. It is important that the ABN clearly stipulates the service, why it is not payable by Medicare, and the amount to be charged. It must be signed by the patient as well.

Note: If the patient chooses option 2 of the ABN, you do not need to bill Medicare; the patient would simply pay for the services at the time of visit. If the patient chooses option 1, Medicare must be billed with modifier GA to indicate an ABN was provided, and Medicare will automatically deny with patient responsibility.

For instructions on proper use of an ABN, as well as forms in English, Spanish and large-print formats, visit https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html. Note that the non-PDF versions allow direct input of information.

The Bottom Line

While it is much easier on our end to not bill for non-covered services, a patient may still want to see that Medicare will not pay (regardless of what you indicate, as once an ABN is used for spinal CMT and a GA modifier is appended to spinal CMT, there is an automatic denial from Medicare) and see the explanation of benefits from Medicare to denote PR or patient responsibility. In this instance, you must still send a claim to Medicare, but the rate may be your regular fee.

A simple rule to remember: If the spinal CMT is covered by Medicare, then the Medicare rate

applies. If it is a maintenance of non-covered spinal CMT with a proper ABN, you may charge the patient your regular rate.

Editor's Note: Submit billing questions to Mr. Collins at sam@hjrossnetwork.com. Your question may be the subject of a future column.

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