



Medicare Repair Kit

Overview for Staff Members

THE FOLLOWING IS A MEDICARE OVERVIEW AND SUGGESTED PROTOCOL FOR PARTICIPATING PROVIDERS. PLEASE READ THE IN-DEPTH ARTICLE AS WELL.

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What Medicare Considers As A Covered Service:

According to Medicare, chiropractors are only paid for a chiropractic manual manipulation of the spine to correct a subluxation, if there is a neuro-musculoskeletal condition for which such manipulation is appropriate treatment. This is the exclusive "covered" service that Medicare allows for chiropractic services.

Two Reasons You Wouldn't Want To File A Claim:

There are two reasons why you would not have to file a Medicare claim form when you see a Medicare patient:

- 1) The Service is not a Medicare-covered Service;
- 2) The Medicare patient does not authorize you to file a claim for the service.

It is also important to understand that Medicare only pays for Active Treatment of a chiropractic service. Active Treatment as it relates to Medicare is that any visits in excess of 8-12 visits (depending upon the source you use) will create an "out-of-profile" status, and potentially result in your Medicare claims being flagged for review.

Avoid filing Medicare claim forms after Active Treatment phase:

You should no longer provide any covered service to the Medicare patient if they participate in the PCD program.

Following is what you want to happen:

1. Note in your records that the patient is released from active treatment
2. Note in your records that the patient is placed in a corrective/stabilization/maintenance/wellness phase of care in your office and what your care plans are
3. Have a printed office policy that defines the various types of care your office provides (corrective/stabilization/maintenance/wellness care).
4. Have a price list that applies to your PCD patients. This should not be a "discount" fee price list. It is a preferred-pricing list for special, preferred-status patients who elect to join the PCD program.
5. Maintain adequate records
6. Continue rendering care per your plan.

The PCD Solution to Medicare:

1. DO NOT bill covered services to Medicare patients who are members of PCD while they are personally paying for you care. As mentioned above, a covered service is a manipulation. Even if it is considered not medically necessary and you know Medicare won't pay for the service, it is still a covered service. ONLY PROVIDE AND BILL FOR COVERED SERVICES TO MEDICARE PATIENTS WHILE THEY ARE PARTICIPATING IN ACTIVE TREATMENT.
2. If you are providing covered services to a Medicare patient (active treatment), be sure to have that patient complete and sign an ABN form, and proceed accordingly pursuant to the ABN choice the patient made. Medicare patients do not need to sign an ABN for non-covered services, nor do you have to file a claim on a non-covered service.
3. Make sure your records accurately reflect your justification for active treatment of the Medicare patient. The patient will need a current/recent history for medically necessary, active treatment. We recommend not exceeding 8 visits for an active treatment phase of care relative to filing Medicare claim forms.

How to explain Medicare & PCD to your Patients:

Medicare DOES pay for the initial, acute phase of your care. That should only take a few visits and you should be feeling much better... Afterwards, if you require continued care (8+ Visits), Medicare will NOT pay for that because they classify that portion of care as maintenance therapy. That's why we offer special PCD plans that guarantee you'll save 25% off of each visit for all non-covered services. Let me show you what our fees are with Medicare and/or PCD versus our Standard Fee. The savings really add up for multi-visit care!

THE (NEW) MEDICARE REPAIR KIT

BY STEPHEN L. BELOW, D.C.

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PCD and Medicare

PCD membership for Medicare recipients can be very beneficial to those patients who require more extensive chiropractic care. Please review and understand the most recent Preferred Chiropractic Doctor position regarding our program and Medicare patients who become PCD members. The following is a discussion regarding the use of the PCD program with Medicare patients, and we have included exhibits to help you more safely negotiate Medicare and help create a better environment to help folks in your community, while maintaining a level of profitability.

According to Medicare, chiropractors are only paid for a chiropractic manual manipulation of the spine to correct a subluxation, if there is a neuro-musculoskeletal condition for which such manipulation is appropriate treatment. This is the exclusive "covered" service that Medicare allows for chiropractic services.

There are two reasons why you would not have to file a Medicare claim form when you see a Medicare patient: 1) The service is not a Medicare-covered service; or 2) The Medicare patient does not authorize you to file a claim for the service. Understanding what Medicare allows and why you don't have to file a claim is critical in protecting yourself from potential Medicare program violations and resulting investigations and penalties.

It is also important to understand that Medicare only pays for active treatment of a chiropractic service. If you have not already done so in your practice, it is critical that you clearly define your Medicare treatment parameters in regards to Medicare-covered services provided by your office. The reality of defining active treatment as it relates to Medicare is that any visits in excess of 8 to 12 visits (depending upon the source you use) will create an "out-of-profile" status, and potentially result in your Medicare claims being flagged for review.

We understand that's not fair. Every patient has individual needs, and often one patient responds differently than another patient. Medicare, HHS, CMS, and the OIG don't care. Your records should reflect there is a new complaint, an exacerbation of a complaint, or a new injury if you are filing Medicare claims on a patient. And you must conclude the active treatment as expeditiously as you can, and at the conclusion of active treatment, you should no longer treat this patient with the expectation that your care is

still medically necessary and that Medicare will pay for the care. As a chiropractor, you've been targeted. If you're trying to dance around Medicare rules in order to get a few more visits out of Medicare, you're going to be glimmering in the cross-hairs of the OIG (Office of Inspector General).

The primary areas of focus (in descending order of importance) by Medicare and their enforcement/reviewing agencies are:

1. Inappropriate billing for maintenance services;
2. The potential sharing of Medicare beneficiaries;
3. The up-coding of services; and
4. The number of services per day.

It is imperative that you reduce your footprint regarding these categories in order to minimize the potential that you will be targeted by Medicare.

We've developed a great solution to help you avoid problems with Medicare, and more importantly, to help you provide care to Medicare patients that need and want your care. Please review this list of recommendations and implement them in order to dramatically reduce your exposure to review and investigation by Medicare-associated agencies.

- I. First, and most importantly, **DO NOT** bill covered services to Medicare patients who are members of PCD while they are personally paying for your care. As mentioned above, a covered service is a manipulation. Even if it is considered not medically necessary and you know Medicare won't pay for the service, it is still a covered service. **ONLY PROVIDE AND BILL FOR COVERED SERVICES TO MEDICARE PATIENTS WHILE THEY ARE PARTICIPATING IN ACTIVE TREATMENT.**
- II. If you are providing covered services to a Medicare patient (active treatment), be sure to have that patient complete and sign an ABN form, and proceed accordingly pursuant to the ABN choice the patient made. Medicare patients do not need to sign an ABN for non-covered services, nor do you have to file a claim on a non-covered service.

III. Make sure your records accurately reflect your justification for active treatment of the Medicare patient. The patient will need a current/recent history for medically necessary, active treatment. You will need an accurate diagnosis to justify active treatment, and you will need to note what your plan is, document patient progress, and delineate the moment of maximum improvement or the point where no significant improvement is expected. Also, note what your future plans with this patient might be. We recommend not exceeding 8 visits for an active treatment phase of care relative to filing Medicare claim forms.

IV. Develop an effective/beneficial process/policy to educate your Medicare patients and create more affordable access to your care. (See the "Retaining Medicare Patients with Better Fee Solutions" exhibit).

V. Implement solutions to reduce adverse Medicare exposure while creating an environment more conducive to making your care more accessible for your Medicare patients.

Avoiding the Medicare Wreck... Putting the Pieces in Place

You take the same way to work each day, and there's a stop sign at an intersection. You've been this way so many times you hardly even look to see if there's traffic coming from the other directions, and you never completely stop at the stop sign. You've been doing that for years. Today is different. It seems that Joe Blow had a fight with his wife last night and he's stayed out all night long drinking. He's finally on his way home and he's headed toward the intersection you go through every morning. He doesn't even notice the stop sign, and you're so comfortable going through this intersection you hardly even notice there's a car coming toward the intersection.

The next lucid moment is when you wake up in the hospital. Bad wreck, and the same thing is going on with Medicare. Looking back, you wish you would have stopped at the stop sign. But it's too late now. The damage is already done. Wouldn't it be a great gift to have some level of foresight and be able to take some kind of action that would result in avoiding the wreck in the first place? You have that opportunity today.

I think if I could give a chiropractor only one piece of advice it would be that the service you provide has enormous value. Sometimes it saves lives. Almost always it improves lives. But as a chiropractor, you've really got to "own" that reality before you can expect a patient to buy in to it. You've got to understand that the majority of your patients also believe your

service has value. Perhaps the trick is to find the sweet spot—that point where you provide a valuable service at an affordable fee that puts your service within the financial capacity of the patient.

Much of our life is simply an extension of what kind of questions we ask, because ultimately those questions determine the course our lives take. The standard question a chiropractor typically asks in regards to Medicare is, "How can I get more visits out of this Medicare patient, or how can I justify a higher service code on this Medicare patient?" I would suggest it's time to start asking a different question, particularly relative to your Medicare patients.

Perhaps the better question is, "What can I do to best serve this patient, while at the same time protecting myself from potential problems with Medicare?" Let's take a look at a realistic hypothetical patient visit to give us a more practical example of what this might look like.

Ms. Jones, a Medicare patient, comes in with lower back pain. You conduct a good history and exam and identify a subluxation of L5. You can help. You need to have a discussion with this patient before you render any treatment or even accept the case. "Ms. Jones, I've found your problem and believe I can help. I want to do this or that, and you need to understand that this is a problem that's been brewing for quite some time and that to achieve maximum improvement of this problem, it will take several weeks or even months of care.

"The good news is Medicare does pay for the initial acute phase of your care. That should only take a few visits and you should be feeling much better. As soon as we get you feeling better, there's still a lot of work we need to do with you to improve/strengthen/stabilize/etc., your condition. The bad news is that Medicare will not pay for that because they classify that portion of care as maintenance therapy, and Medicare won't pay for maintenance care.

"But we have a great program called PCD you can take advantage of that will help you get the care you need more affordably, even though Medicare won't pay for that care. I wanted to let you know about that because I know you want to get as much improvement as you can. Let's go ahead and get started on getting you feeling better, and when we complete your acute phase of care, we can review the affordable financial options you have. Does that sound good to you?"

This is all assuming that Ms. Jones wants to maximize her results in your office and desires to move forward with longer-term care. When you use a dialog such as I have presented here, several things happen, or should happen. First, you've established that Medicare payments are available, but that they are limited. The

patient will be glad that Medicare pays something, and hopefully, if you've presented it correctly, the patient will be glad that you offer an affordable fee solution. The only negative in this scenario (relative to fees) is that Medicare won't pay for maintenance care. Offering an affordable fee solution should overcome this negative or at least minimize the fee resistance.

Secondly, you've established a sort of "stop-loss" factor in your internal policies/procedures. In the stock market, a "stop-loss" is a device you can establish that sells a stock you own if it loses a certain percentage. If your stock goes down 10% and you have a 10% "stop-loss" on that stock, your broker (or service) will sell that stock to avoid any further loss on the stock. The "stop-loss," as it applies to our circumstances, is that you begin this Medicare case fully aware that active treatment will be for a limited number of visits (we recommend to not exceed eight visits), and knowing that you will "stop" active treatment at, or before that point enables you to avoid the "loss" of being reviewed or investigated by the OIG.

Third, you have established that you provide solutions, and that's why Ms. Jones is there in the first place. You've found the patient's physical problem, and you have a solution. You've reinforced that there is a near-term fee solution in that Medicare will pay for active treatment. You've also presented a longer-term, personally-affordable solution that assists this patient in achieving better outcomes, which virtually every patient wants. Putting the desirable outcome in closer financial reach further strengthens the probability that this patient will continue care and provide additional income to you.

Fourth, and perhaps most importantly, you have added value to your service via your ability to solve problems, the consumer-friendly policies you have, your evident desire and capacity to help folks, your concise and understandable policies, and your glowing personality! In short, the big package of "you" comes through to your patient as someone who is professional, competent, affordable, and more concerned with a patient than with the fees they might extrapolate from an insurance company. Everything you do in your office ought to be with the intention of adding value. When you do that, it shows, and those folks on the receiving end of that keep their appointments and tell their friends and families about you.

So, you've done everything according to the book with active treatment as it relates to Medicare. What's next?

Let's assume you're going to see this patient eight times and complete Medicare claim forms for those visits. Two or three visits prior to the conclusion of active

treatment you need to be preparing the patient for what's to come—a change in the financial relationship. Now your patient will have to start paying your fees out of pocket. But that's okay, because you know what you offer has tremendous value, and you convey that to your patient.

So, you need to have some dialog about this and prepare your patient to take action to help ensure that your care will be affordably available at the conclusion of active treatment. One critical thing to remember about a Medicare patient is that if you're providing a "covered" service, you need to submit a claim on it (unless the patient does not authorize you to file a claim on his or her behalf.

As far as protecting yourself from adverse Medicare outcomes is concerned, the following statement is, by far, the most critical thing you should do concerning the inappropriate filing of Medicare insurance claim forms. If your active treatment phase of care is concluded, and you want to avoid the necessity of filing a Medicare claim form, then you should no longer provide any covered service to the Medicare patient.

Following is what you want to happen:

Ms. Jones elects to join the PCD program so she can more affordably continue her care. You need to:

1. Note in your records that Ms. Jones is released from active treatment, and she has attained a maximum level of improvement for this immediate condition.
2. Note in your records that Ms. Jones is placed in a corrective/stabilization/maintenance/wellness phase of care in your office and what your plans are for this patient.
3. Have a printed office policy that defines the various types of care your office provides (corrective/stabilization/maintenance/wellness care). (Examples are included in the exhibits.)
4. Have a price list that applies to your PCD patients. This should not be a "discount" fee price list. It is a preferred-pricing list for special, preferred-status patients who elect to join the PCD program.
5. Maintain adequate records (example in exhibits).
6. Continue rendering care per your plan.

Why Do I Need to Use PCD in My Office?

It should be fairly obvious, if you've read the preceding discussion, that an easy Medicare solution for your office could simply be to not provide any covered services to a Medicare patient beyond the active treatment phase of care. This would be correct. If the only issue was finding a solution to active treatment vs. maintenance care, all you would need to do is be sure not to provide a covered service to a Medicare patient post active treatment. It would be nice if it were only that simple.

There are several laws you should be aware of at the federal level. While these laws specifically refer to federally-insured folks, you should also be aware that the case law associated with these federal regulations has already served as precedent in other civil and criminal courts. So, these federal laws are essentially De Facto precedents for non-federal court determinations. Private insurers are using these laws as precedent in their cases. It's federal law, and by extension, has standing in non-federal court to serve as precedent. I'll briefly mention the laws here, and if you want more information simply Google the specific law.

The False Claims Act (FCA), a civil and criminal law, protects the government from being overcharged or sold shoddy goods or services. It's illegal to submit claims you know, or should have known, are false or fraudulent. If a claim results from a kickback or violation of the Stark law, that may, as well, render the claim fraudulent. *Under the FCA, no specific intent to defraud is required.* So, technically, you could be in violation of the FCA if an OIG investigation determines that you had an improper diagnosis, you exceeded active treatment time frames, or didn't have adequate records to justify your service. Penalties include fines up to three times the programs' loss, plus \$11,000 per claim filed, removal from the Medicare program, and imprisonment.

The Anti-Kickback Statute (AKS) is a criminal law that prohibits remuneration to *induce* or *reward* patient referrals...or the generation of business involving any item or service payable by federal health care programs. Remuneration includes anything of value. It applies to all sources of referrals, even patients. It's geared more toward eliminating referral schemes, for example, where an entity buses Medicaid recipients to a clinic for "free" care, or even for a fee paid to the patient. But it also covers things as mundane as a good-faith offer by a provider to extend a discount to a federally-insured patient. Violators face up to \$50,000 per kickback, plus three times the amount of the remuneration, plus imprisonment.

The Physician Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive

"designated health services" from entities with which the physician or an immediate family member has a financial relationship. So, if you have a financial interest in any other related health care interests, such as labs, DME, PT, etc., you could be in violation of the Stark law if you're referring patients to the business you have financial interest in. If you want to get more "nit-picky" with this law, it applies to ownership, investment or compensation arrangements. So, technically, if you owned stock in a local hospital you referred to, you could be in violation of the Stark Law.

The point is there are serious laws on the books and you need to do your best to stay under the radar in regards to these laws—especially since it is no secret that the OIG is now targeting chiropractors and is obviously "locked-and-loaded" to attack chiropractors who may, or may not, be guilty of violations of these laws. An interesting question to consider is how many chiropractors really believe that if the OIG investigates them that the OIG won't find anything wrong with their records? If you don't fit the OIG's "out-of-boundaries" profile, the likelihood of review is significantly less. That's the position I want to be in.

Value and Utility

In the world of commerce, I believe the single most important element of successful commerce is the element of value. Provide greater value, enjoy greater success. Some of that value is what you create through your persona and what is perceived by the recipient. Some of that value is intrinsic. Some chiropractors have a greater propensity to generate more perceived value through their style and personality. All chiropractors have in their possession the intrinsic value of the services they offer to their patients...what we provide is valuable. Patients wouldn't come in if it wasn't.

Then, there is also the issue of utility. Many chiropractors don't consider this issue. The hard reality about utility is that there is a point where the value of a good or service loses some utility relative to the circumstances surrounding the good or service, particularly, and often exclusively, related to the cost of that good or service. You might enjoy the first milkshake you get so much that you decide to get a second. The second wasn't quite as good as the first, but it was still good, so you decide to go for a third milkshake. You don't even finish the third milkshake, and after the first or second sip it wasn't even good anymore. You reached the point of diminishing marginal utility. The product or service now did not have enough "value" to consider purchasing it again.

The same sort of thing happens in your office. A patient comes in with acute pain. You provide service and in a visit or two the patient is much better. They perceive high value/high utility.

Treatment Parameters Exhibit and Transitioning Out of Active Treatment

Active Treatment is a critical component to consider when caring for your Medicare patients, because HHS/OIG is using "Active Treatment" as one of their primary tools to determine if the care you rendered was reimbursable—or improperly provided and potentially in violation of related laws.

It's not a black-and-white issue, so our best recommendation is to err on the conservative side, i.e.: As soon as your Medicare patient achieves significant improvement with their subjective complaint, or you're not achieving "documentable" improvement, it's time to note in your records that "Active Treatment" has concluded for your Medicare patient's condition.

It's important to note how HHS/OIG arrived at their current position in regards to targeting chiropractors.

Here's a basic rundown:

1. They identified claims with "AT" modifiers for Medicare patients with more than 12 visits.
2. Medical reviewer contractors reviewed the claims (188 claims).
3. Records were reviewed for each treatment episode to identify initial visit and subsequent visits to determine whether each sampled claim was active/corrective treatment or maintenance therapy.
4. They determined the extent chiropractors supported their use of the AT modifier with proper documentation indicating:
 - a. Active/corrective treatment
 - b. Whether claims were coded properly
 - c. Whether documentation met the manual requirements

What They Found:

1. Medicare improperly paid \$178 Million for maintenance therapy.
2. Efforts to stop maintenance therapy were largely ineffective.
3. Claims data lack initial visit dates for treatment episodes, hindering identification of maintenance therapy.
4. Chiropractors don't comply with manual documentation requirements.

Reviewers indicated that treatment plans are an important element in determining whether treatment was active/corrective in achieving specified goals and:

1. 43% of claims lacked treatment goals.
2. 17% lacked objective measures.
3. 15% lacked recommended level of care.

So, understanding the primary issues HHS/OIG have with chiropractic claims, it would be logical to assume that if a chiropractor addressed these issues then their

exposure to review and penalty should be reduced. Having said all this, the following is an outline you can use to address the primary concerns Medicare has in regards to your delivery of health care to Medicare patients.

Important Points to Include with Medicare Patients

1. Have a current/relevant history on your Medicare patient. More specifically, have a current/relevant reason why your Medicare patient requires "active treatment" for a condition. This reason might be a new injury, an exacerbation of a condition, or an idiopathic presentation of a new complaint. Whatever the reason, the subjective presentation (history of condition) should provide justification for you to provide "active treatment" to this patient. If this Medicare patient has been your patient for multiple years, the history you originally did on the patient eight years ago probably isn't going to justify "active treatment." Keep it relevant and keep it current if you're going to file Medicare claims on a patient.
2. Make sure you record your objective findings and that these findings correlate to the level of care you are providing. If you don't have a history and objective findings that justify a multiple level Medicare service code, don't file a higher code on your patient.
3. State what your specific goal or plan is for this patient relative to your objective findings and the current complaint/history. The goal/plan needs to include what you hope to achieve with the patient, what you're going to do, when you're going to do it, and how long you're going to do it. For example, Ms. Smith has neck pain from a current injury, you've found relevant objective findings, you want to do xxx and xxx for xxx visits and plan to achieve significant reduction in pain, muscular spasm and increased range of cervical motion, assessing the patient each visit to note progress. If the patient is not showing improvement in xxx visits/days, you will re-assess/refer the patient. You get the idea, just a brief notation in your records to verify you have a plan and a goal with this patient.
4. If you're filing Medicare on your patient, and you want to minimize your exposure to review, you need to provide your "billable" care in 8-12 visits. Billable care is "active treatment." If you exceed these visit levels, just know your chances at being reviewed are dramatically increased.

5. When you conclude an “active treatment” phase of care you need to record that in the patient’s records for two primary reasons. First, you need the documentation to verify that you have concluded the “active treatment” for this patient and are either releasing the patient or making a new set of recommendations. Secondly, this is the point where you redefine your patient’s status as a patient participating in a non-covered Medicare service. It is important to include this in the records because if you are reviewed you need a clear line of demarcation between what was “active treatment,” and what is now a maintenance, wellness or other non-covered levels of care.

More on the Conclusion of Active Treatment

Many chiropractors might think that the conclusion of “billable” care for a Medicare patient is the end of the patient coming in, because now the patient is faced with paying for services themselves. That is not true, and is largely a belief defined by the perception of the individual chiropractor. Some Medicare patients might stop coming in when Medicare stops paying, but many will continue care and happily pay out of their own pockets for that care—IF—1) they value the care; 2) the care provides an improvement in the quality of their life; 3) the care is within their financial capacity to purchase. The first two reasons are totally within the realm of the provider. The third reason is something that PCD can help you with.

Concluding “active treatment” is a transition from third party compensation to two party compensation. The insurance company (Medicare) is now out of the picture and you’re looking directly to the patient for compensation. How can you more effectively make this transition, and how do you move from “active treatment” to a non-covered phase of care, relative to your patient interaction and the Medicare implications? Below is a flow chart of how this transition might look in many practices:

Assumption: Medicare patient chooses active treatment to be billed to Medicare—

DC:

- Informs the Patient
- Plans/goals of a.t.
- Short term vs. long term benefits
- Medicare policy review
- Introduction to care after active treatment

Patient:

- Patient choice—crisis or maximum benefit
- Signs PCD form—indication they understand what Medicare pays for and what it doesn’t pay for
- Signs ABN

Transitioning from active treatment to non-covered services—

DC:

- A.T. is concluding/has concluded
- Recommendations have been provided and noted
- Fee Discussion
- Charge for non-covered services only
- No claims submissions
- Adequate documentation

Patient:

- Perceives value in service. Willing/capable to invest in care.
- Has affordable fee enabling greater propensity to continue care.
- Creates a higher value relationship where patient perception is more favorable vs. negative due to resistive fees.
- More likely to 1) comply; 2) refer; 3) create income for practice; 4) be long-term patient.

Once the patient is successfully transitioned your policies and procedures should support regular, long-term chiropractic care as valuable tool your patient uses to enhance/improve the quality of their life. Failure to have policies/procedures in place to support this kind of educational process often results in patient frustration and lack of satisfaction—quite simply because the patient does not understand their care is an important part of maintaining/improving the quality of their life.

Closer analysis of the Flow Chart

Medicare patient opts for active treatment and claims are filed:

Provider Actions

Plans/goals of Active Treatment—refer back to “Important points to include with Medicare patients.”

Short-term vs. Long-term Benefits—you should have a discussion with the patient about what their goals are in your office. Do they only want pain relief, or do they want to improve the quality of their life? This is often a discussion that is ongoing. Initially, most patients come in seeking resolution of a short-term complaint. You should certainly address that and offer your best solution to that issue. Many patients don’t understand that there are indisputable advantages to participating in longer term chiropractic care. You should certainly focus on informing your Medicare patients about that, as well.

Medicare Policy Review—It’s important to plant seeds early in a relationship. Basically, you want to “sow” the types of seed information you’d like to see grow. If your Medicare patient would benefit from longer term care, and that’s what you’d like to provide, you should plant that idea in the mind of your patient at your earliest opportunity, so the seed will begin a

germination phase and be more receptive to further growth.

Reviewing Medicare coverage helps you set the tone, perceptions, and expectations, of a doctor/patient relationship, particularly relative to financial issues. First, you need to be crystal-clear about what Medicare covers...“Ms. Jones, you’ve got this problem...We can help you with that and your Medicare pays for active treatment, which means that when your condition is stable/improved/maximized (whatever the case may be) then the active treatment phase of your care is concluded and Medicare will no longer pay for any additional care you need. Do you understand that?”

Secondly, if this Medicare patient needs care beyond active treatment, you should introduce the patient to the benefits of longer-term treatment early on in the patient’s care. You want to plant that seed in the patient’s mind so the patient will be, hopefully, more prepared and more receptive to the choice of longer term care when the patient crosses that bridge. It would sound something like this: “Ms. Jones, I’ve reviewed your case and we can certainly help you with the problem you have. I also found that you have other issues that we can help you with...Is this something you would be interested in improving/resolving? Unfortunately, your Medicare insurance doesn’t cover any subsequent care, but I wanted to let you know we have a great plan called Preferred Chiropractic Doctor for our Medicare patients that makes our care very affordable, and helps you feel better and improve the quality of your life! Let’s get you doing better now, and I’ll let you know more about our affordable fee plan when we get you feeling better!”

It’s important to inform the patient about the limitations of their insurance, so they’ll know and you can avoid negative surprises. It’s also important to introduce and reinforce the concept that they need longer term care and can afford to pay for your services, regardless of what Medicare pays for. Put the seed in the ground and nurture it so it grows the way you want it to!

Emphasizing Maximum Benefits—People have a certain perception about the things they are willing to purchase. This “perception” is influenced in numerous ways. One way that you can influence this perception is to focus on the results, outcomes and benefits a patient might receive from your care. Don’t lie or make unrealistic promises, but tell the truth about what improved function might mean as it relates to the quality of your patient’s life. Listen to your patients. Find out what’s important to them. Let them know how what you’re doing will benefit whatever goals/aspirations/desires they have. Create more value in your service so your patients will better realize the value you offer. Many of these Medicare patients will opt for that value, and how you present and define this value is an important part of that equation.

Introduction of Post-Active Treatment Care—Early on in your patient interaction you should inform your Medicare patient about the options they have beyond active treatment for their condition. This is simply another example of planting the seed and nurturing it, so your patient will have a better understanding of what’s available and what’s required in order to address their health care issues. The more your interaction focuses on quality of life patient perceptions, and how you can enhance that quality of life, the greater the likelihood of that patient understanding and embracing the value of what you have to offer.

Patient Actions

Patient Choice—You want your patient to make the choice regarding the type of care they want to participate in. When you’ve had the opportunity to inform a patient about the value of what you provide, the majority of those patients will opt for longer-term care. Some will not. So the point is, don’t try and force folks to participate in something they don’t want to participate in. Either accommodate their “choice,” or don’t accept them as a patient in the first place.

Sign ABN—If you’re providing covered services you need to have your Medicare patient sign an Advanced Beneficiary Notice.

The Transition from Active Treatment to Non-Covered Services

Provider Actions

Formal Transition—note in your records that this patient has been released from active treatment, and note the reasons why. Either the patient has shown adequate response to be released from active treatment, or the patient has not. Either way, note the reason why the patient is now released from active treatment.

New Recommendations and Plans—You’ve released the patient from active care. What’s the plan now? You need to identify the reasons this patient still needs your care and you need to identify what you are going to do with this patient now. You should have been preparing your patient for this during the active treatment phase, and now you clearly demarcate that the patient is participating in a new phase of care.

For example, Ms. Jones came in with neck pain and now the neck pain is gone. However, Ms. Jones had associated issues...DJD, muscle weakness, dizziness, etc. Your recommendation might now be to address these related findings, and your plan might be to utilize examination evaluations, physical therapy modalities, exercise therapy, or a host of other non-covered services to address Ms. Jones condition. If you are charging for a covered service, that covered service falls within the purview of Medicare regulations. If you are not charging for, and providing covered services,

your services do not fall within the purview of Medicare. The recommendations and plans need to be recorded in your patient records, and be sure to inform your patient about what you're doing, so your patient will be on the same page as you are.

Fees—Somewhere in this process you need to have a fee discussion with your Medicare patient. Ideally, this discussion would be toward the end of an active treatment phase. Basically, fee discussions should relate: here's what we're going to do and here's what your fees are going to be. If your fees are too high, you'll have low participation. If they're too low, you can't afford to provide the service. So you have to find a fee that works for you and the patient.

We also recommend that you have a written fee document, particularly for long-term, non-active-treatment Medicare patients. This fee document should list the various services you provide and the associated fees for those services. Covered Medicare services should not be included on this document. It is a good idea to have a normal/regular fee stated on this document, and a contrasting PCD fee listed to help identify the significant savings a Medicare patient can enjoy with PCD membership.

Non-covered Services—Suffice it to say, if you want to stay outside of the purview of Medicare, only provide non-covered Medicare services. As you know, the only covered Medicare service is "manual manipulation...." Due to various federal regulations, do not discount your care on covered services.

Your Office Policy for Medicare Patients—you need to have an office policy regarding your Medicare patients, and how your care and charges relate to these patients. This policy needs to be written and, at a minimum, stored/recorded in your office policy documents. Ideally, this policy would be available, and given to Medicare patients, particularly those patients who continue longer term, non-covered care in your office.

Per example, the policy might look something like this: "It is the goal and policy of this office to provide care to our patients that is in the best interest of those patients. Medicare regulations allow for reimbursement of limited services, for a limited amount of time (and we happily assist you with that reimbursement via claims submission?). Some Medicare patients require care that is not covered by their Medicare insurance and in our effort to provide you with the best, and most affordable care, our professional recommendations may be that you participate in care that is not covered by your Medicare insurance. We will inform you of what our recommendations for optimal improvement in your condition are, and provide you with preferred fees on any non-covered Medicare services we may recommend and provide to you."

An ideal way to manage these types of Medicare patients is to create a global fee scenario. That is to say that you might provide an exam/assessment at each visit and multiple other non-covered services. Think in terms of time spent, relative to your desire to help folks improve the quality of their life. If it takes you 10 minutes to serve this patient and your goal is to make \$200 per hour, then the global value of your service (time) is 1/6th of \$200, or \$33.33 for that particular visit. These are just examples, and you would need to plug in the figures that work for your particular practice.

The preceding example should be given to your Medicare patient that is electing to continue with longer-term care. In the event of a review or audit, having this document goes a long way in verifying that your service and billing activities are consistent, compliant, non-discriminatory, and not in violation of various Federal laws.

Medicare Claims Submissions—If you are providing a covered service to a Medicare patient you are required to file that visit (unless the patient requests that you do not bill Medicare {ABN, option 2}). So, if you are providing covered services to a Medicare patient, it's best to report these visits and not discount these visits.

Documentation—Regardless of whether you file a claim or not, you should keep records that document the necessity and progress of the care you are providing.

Patient Actions

Value—If a patient has opted in to a longer-term care scenario, you can be sure that patient has values your service.

Financial capacity—if the patient perceives value and has the financial capacity to participate in care, you have a great patient that can receive all the benefit they deserve from your care, and this patient will be very likely to continue care and become a recurring source of income.

Perception—The primary complaint we get from PCD patients is in regards to fees. Fees create the number one negative perception, by far, about chiropractic care, as far as our experience has shown. Of course when a third party is paying for the care, this perception is not affected as much. But when folks have to pay for care themselves, it becomes a major issue. If you create policies in your office, like offering PCD to create more affordable and accessible care, you can greatly diminish the negative impact higher (third-party-based) fees have on the perceptions of your patients. Why does this matter?

Because patients that have more positive perception about you and the care you offer will be more likely to 1)comply; 2)refer others; 3)be a long-term, satisfied patient that produces repeat income for you.