Chiropractic Care of Minnesota, Inc.

Policy Title:	**Patient Billing**		
Policy Number:	CRM - 009	**Effective Date:**	10/01/2010
		Last Revision Date:	6/16/15
		Last Approval Date:	6/16/15
Responsible Area/Individual:	Credentialing		
Purpose:	To establish guidelines for billing patients for services non-covered services.		
Regulation Reference:	HIPAA 164.522 (a)(1)(vi)(B), 42 CFR §§ 422.566 – 422.576, Medicare Managed Care Manual, Chapter 4, section 170		

POLICY:
It is the policy of Chiropractic Care of Minnesota, Inc. (CCMI) that contracted network providers notify patients and obtain proper patient acknowledgement of member liability prior to delivering non-covered services for which the member will be billed. Failure to obtain acknowledgement as defined below will annul the patient's liability for any non-covered service provided.

BACKGROUND:
CCMI network providers are expected to understand general benefit limitations associated with each line of business that CCMI administers, e.g. Commercial, Medicare, Medicaid, etc. Further, CCMI requires its contracted providers to notify patients of non-coverage, and the related financial liability, prior to the delivery of any such service. Related processes must comply with all state and federal requirements in order to support patient billing.

PROCEDURE:
Commercial and Medicaid Members
To reduce risk to the CCMI provider, CCMI strongly recommends use of the CCMI Non-Covered Services Financial Disclosure Form to clearly communicate chiropractic benefit limitations and document the patient's agreement to financial liability related to non-covered services. To ensure the patient's clear understanding, the form should be filled out in its entirety. Forms that do not contain the required elements listed below will be determined to be invalid, annulling the patient's financial liability.

Should the provider elect to use their own form to document proper member notification and patient agreement to financial liability, it must include the following elements:

1. Provider name.
2. Provider address.
3. Detailed list of non-covered services for which the member may be billed **and** the cost associated with each.
4. Signature of the provider or health care representative who explained the Financial Disclosure Form and discussed available options to the patient.
5. A clearly written statement indicating the patient's understanding that the identified services are not covered by insurance and patient agrees to pay for them in full.
6. Patient name.
7. Patient signature.
8. Date of patient signature (note: the signature must be obtained prior to the service being rendered and updated when benefits change or a maximum period of 12 weeks has lapsed).

Provider may not bill the Commercial/Medicaid patient, or the payor, for the applicable non-covered services if they fail to obtain appropriate documentation as described above. Further, failure by the provider to obtain and/or produce acceptable forms upon request could lead to corrective actions or change in network participation status.

Medicare members

- **When the service is never payable when rendered by a chiropractor based on the patient's coverage, e.g. exam, modality, procedure, etc.:**
  Prior to rendering the service, provider must obtain and retain the patient's written consent to receive, and accept financial liability for the non-covered service(s).
- **When the service being delivered may, or may not be covered, e.g. spinal manipulation believed to be in a maintenance or wellness phase of care:**
  CMS requires that a pre-service organization determination (authorization request) be submitted to confirm coverage or lack thereof. Patients will be notified of an approval or denial through distribution of the standard member communication, i.e. Notice of Denial of Medical Coverage, or Integrated Denial Notice, prompted by the organization determination. This communication will also provide the member with any applicable appeal rights.

  If the service is denied and the patient chooses to receive the denied service, providers must obtain and retain the patient's written consent to receive, and accept financial liability for the non-covered service, prior to the service being rendered, in order to bill the patient. Only denied services, i.e. spinal manipulations found to not be medically necessary, are eligible for patient billing.

  If either of these steps is not completed prior to delivery of the service, all patient financial liability related to the non-covered service will be annulled.

Obtaining patient consent

To support patient billing related to non-covered services rendered to Medicare members, CCMI has developed a Medicare Member Consent for Non-Covered Services Form. Use of this form serves as documentation of the patient's written consent to receive, and accept financial liability for the listed non-covered service(s). While it is recommended that providers utilize this CCMI form, providers may elect to use another version of a consent form however, it must include the following elements:

1. Provider name.
2. Provider address.
3. Detailed list of non-covered services for which the member will be billed **and** the cost associated with each.
   Note: for spinal manipulations, the listed services must align with the organization determination (authorization) denial for both care volume and timeframe, e.g. 6 visits over 4 weeks. Spinal manipulations that have not been denied through the organization determination process can not be billed to the patient.
4. Signature of the provider or health care representative who explained the Consent Form and discussed available options to the patient.
5. Patient name.
6. Patient signature (note: The signature must be obtained prior to the service being rendered and updated when benefits change or a maximum period of 12 weeks has lapsed.
7. Date of patient signature (note: the signature must be obtained prior to the service being rendered and updated when benefits change or a maximum period of 12 weeks has lapsed).

Per the guidelines from Centers for Medicaid and Medicare Services (CMS), Managed Care Organizations, e.g. health plans (and their delegates) may not use the CMS Advanced Beneficiary Notice (ABN) Form to hold the patient financially responsible for any rendered service.

MSHO members

Minnesota Senior Health Options (MSHO) is a product that includes coverage through both Medicare and the Minnesota Medical Assistance (Medicaid) program. When treating MSHO members, all Medicare and Medicaid rules must be followed. This includes initiation of a pre-service organization determination (authorization review) to confirm lack of coverage for spinal manipulations, and/or collection of the patient's written consent to accept financial liability, when patient billing occurs. Please see above for detailed patient billing requirements.

Note: *Revisions to the HIPAA Privacy Rules now requires a provider to grant an individual's request* ***not*** *to disclose PHI to a health plan for a health care item or service where the individual has agreed to pay out of pocket.*

REFERENCES/ATTACHMENTS:

CCMI Non-Covered Services Financial Disclosure Form
CCMI Medicare Member Consent for Non-Covered Service Form
Non-Covered Services Financial Disclosure Form – Frequently Asked Questions
Billing Medicare Members; Policy Change 7/1/15 – Frequently Asked Questions