FAQ: Billing Medicare* Members; Policy Change 7/1/15

*Also impacts dual eligible members where the health plan sponsored Medicare policy is primary, e.g. MSHO.

Q. What is changing?

A. For potentially non-covered services rendered to Medicare members, e.g. spinal manipulations (since they are covered only when medically necessary), a provider must obtain an authorization denial, prior to the service being rendered, in order to bill the patient. In addition, CCMI has developed a new consent form, specifically to be used when providing non-covered services to Medicare members.

Execution of a Financial Disclosure Form alone is no longer sufficient documentation to support Medicare patient billing for spinal manipulations, even if the provider is confident the care is maintenance in nature and therefore excluded from the patient's coverage.

Q. What prompted the change?

A. In May 2014, the Center for Medicare and Medicaid (CMS) sent out a memo addressing the "Improper Use of Advance Notices of Non-coverage." CMS Clarified that (1) an organization determination is the appropriate notice that must be used for Medicare Advantage patients when a provider is holding the patient financially responsible, and (2) Advance Beneficiary Notices (ABN's) are to be used for Original Medicare and not Medicare Advantage.

Q. What are the new requirements for billing a Medicare member for spinal manipulations when the care being delivered is maintenance in nature?

A. CMS has stated that providers may not bill members for any potentially covered service unless that member understands that the service will not be covered, and has been given appeal rights, prior to the service being rendered. In order to bill patients for spinal manipulation which you believe to be maintenance in nature, you must do two things prior to rendering the service:

1. Submit an authorization request to the appropriate entity, and obtain a medical necessity denial, and
2. Obtain written patient consent to receive, and pay for the non-covered (denied) service. CCMI's "Medicare Member Consent for Non-Covered Services" form can be used to obtain and document patient consent.

If both requirements have been met, providers may collect from Medicare patients (for non-covered services) at the point of service, or via distribution of a bill. Failure to complete either of these requirements will annul the patient's financial liability.

Q. What if I expect the spinal manipulations to be denied through the authorization process but my request is approved?

A. Only manipulations with a formal denial can be billed to the Medicare patient. If services are approved through the authorization process, the patient may not be billed and claims may be submitted to ChiroCare for payment through the insurance benefit.

Q. What happens if I don't obtain the required denial from the health plan or CCMI before the manipulation is rendered?

A. If a denial is not obtained from the health plan, or CCMI as its delegate, before the service is rendered, the provider may not bill the Medicare patient for the service. If collection from the patient occurs without the denial, and the patient files a complaint or grievance, the provider will be required to refund the patient. In addition, if a provider is associated with 3 or more patient billing issues within a year, that provider may be subject to disciplinary action, including potential termination from the ChiroCare network.

Q. What happens if I don't obtain the patient's written consent to receive and pay before maintenance care is rendered?

A. If appropriate patient consent is not documented prior to delivering the non-covered service, the provider may not bill the Medicare patient for the service, even if a formal denial notice was previously issued by the health plan or CCMI. If collection from the patient occurs without documented consent, and the patient files a complaint or grievance, the provider will be required to refund the patient. In addition, if a provider is associated with 3 or more patient billing issues within a year, that provider may be subject to disciplinary action, including potential termination from the ChiroCare network.

Q. When is it acceptable for me to bill a Medicare patient for services that are never covered?

A. Prior to rendering a service never eligible for reimbursement, providers must obtain patient consent to receive and pay for the non-covered service. CCMI's "Medicare Member Consent for Non-Covered Services" form can be used to obtain and document patient consent. It is not necessary for providers to obtain a denial from the health plan or CCMI to bill members for services that are always excluded from chiropractic coverage, e.g. exams, procedures and modalities. With documented consent, providers may collect from Medicare patients for excluded services at the point of service, or via distribution of a bill.

Q. Why can't CCMI's Financial Disclosure Form be used to document the Medicare patient's consent to receive non-covered services?

A. CMS has rigid standards for the clarity of communication with Medicare members. Because chiropractic benefits available to Medicare members differ from those available to other members, a separate, Medicare-specific form was developed to support patient billing.

Q. I'm a Category A provider so don't typically submit authorization requests. What is the process?

A. HealthPartners members: CCMI is no longer coordinating clinical reviews for Medicare (or MSHO) members. Providers may contact the member services phone number on the member's ID card for instructions to initiate a clinical review.

   UCare members: Providers who are unfamiliar with CCMI's authorization submission process can find submission instructions in CCMI's Provider Manual or call CCMI's Provider Services team at (888) 638-7719 for assistance.

Q. Is there any change to the requirements associated with patient billing for Commercial or Medicaid members?

A. No, because these changes are being driven by CMS, which has oversight for Medicare products, the revised requirements are only applicable to Medicare membership, and MSHO members which have coverage through both Medicare and Medicaid. Providers are however, still required to meet CCMI's standard requirements around patient communication and documentation before billing commercial and Medicaid patients for any non-covered service.

Q. Who can assist me with additional questions?

A. For additional information or assistance regarding this policy change, please contact CCMI's Provider Services Department by calling (888) 638-7719.

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