
HNS Network News



Physician News

Quarter 3, 2009

Would a \$900,000 Post Payment Audit Ruin Your Day? Could it Ruin Your Life?

Post payment audits of chiropractic health care records are increasing at an alarming rate. One of your colleagues was audited by BCBSNC and recently received a post payment audit letter stating that he owed BCBSNC **in excess of \$900,000.**

HNS is aware of more than 60 chiropractic audits in North Carolina within the last four months... Of these, the repayment demands ranged from \$150,000 to \$900,000.

What are payors finding during these audits that result in these repayment amounts?

- Waiving copayments, deductibles and/or coinsurance
- Use of manual therapy (97140) together with CMT codes, without establishing/documenting medical necessity
- Inappropriate and overuse of massage therapy (97124)
- Lack of reduction in therapies as patient condition improves
- Lack of documented medical necessity for treatment provided
- Failing to file claims for all covered services provided (includes providing free exams and x-rays, etc.)
- Upcoding CMT codes
- Upcoding E/M codes
- Billing for maintenance/supportive care
- Inappropriate billing for consultations
- Inappropriate billing for radiology consults
- Failure to adhere to NC BOE Practice Guides
- Failure to adhere to Corporate Medical Policies

The *HNS Practice Protection Plan* was designed to provide you with the information needed to help you protect your practice. This manual includes valuable information on audit “trigger” areas and includes HNS documentation, coding and practice policies, payor corporate medical policies, *NC BOE Practice Guides* as well as other information needed to protect your practice. **If you have not become thoroughly familiar with all of the information included in the *HNS Practice Protection Plan* and incorporated these policies into your practice, you are at risk of a post payment audit.** The *Practice Protection Plan* has been updated to include the revised *BCBSNC Corporate Medical Policy* and the newly revised *NC BOE Practice Guides*. The *HNS Practice Protection Plan* is available on the secure portion of our website. We urge you to promptly review this manual and make sure that your office is complying with all policies.

Audit Triggers - Time Based Therapies

(Constant Attendance and Therapeutic Procedures)

The inappropriate use and reporting of **time based therapies** increases your chances of post-payment audits! Payors are paying close attention to providers reporting CPT codes 97124 (massage) and 97140 (manual therapy.) Nationally, post payment chiropractic audits have revealed that these codes are often reported without the appropriate documentation to establish medical necessity for these services and/or for the number of units reported.

Health care payors have the ability to review provider billing histories from information reported on health care claims. Based on these billing histories, payors may conduct a post payment audit to determine if the services were appropriate, were medically necessary, and were properly documented and billed.

With respect to time based codes, triggers for post payment audits include:

- Reporting ANY time based code for more than one unit, with particular focus on massage therapy (97124) and manual therapy (97140).
- Use of 97140 together with a chiropractic manipulation (CMT) code.

Helpful Reminders:

1. Documentation contained in the health care record must clearly establish the medical necessity for all covered services reported.
2. Treatment must be consistent with *BOE Practice Guides* and payor corporate medical policies.
3. When reporting time based codes, the health care record must reflect the actual time the services were performed.
4. There should be a reduction in the use of therapies as the patient's condition improves.

Page 298 of the *2009 ACA Chiropractic Coding Solutions Manual* states “...**each unit of 97140 describes 15 minutes of office time – it normally does not take 45 minutes to perform manipulative therapy and payers are fully aware of this.**”

All time based therapies (constant attendance and therapeutic procedures) are billed in 15 minute increments. When these services are provided for *less than 15 minutes, the code must be appended with Modifier 52. Please remember the actual time the service was performed must be documented in the patient's health care record.*

IMPORTANT NOTE on Manual Therapy (97140)

At the present time, payor's claims processing systems can accept only **one modifier** per CPT code. Manual therapy, when performed together with a CMT code, must be submitted with Modifier 59 to indicate a 'distinct procedural service'. Even if the service was reduced and would thus normally require the use of Modifier 52 and Modifier 59, **always append this code with the Modifier 59, or the service will be denied.** (Note: If no CMT code is being reported on the same date of service as the 97140, and the service was reduced to less than 15 minutes, then append with Modifier 52.) ***Please remember that the health care record must always reflect the actual time the service was performed.***

We hope this information is helpful. We will continue to update you with information that can help you protect your practice and we urge you to download our updated *HNS Practice Protection Plan* and the *HNS Provider Instruction Manual* from our website.

Get Paid for the Services You Provide...

CIGNA HealthCare Announcement

CIGNA HealthCare will not pay for ANY services **other than those listed on the new CIGNA fee schedule**. *Any other services billed will be denied by CIGNA HealthCare.*

1. Please print a copy of the new CIGNA fee schedule and keep it in a convenient location for quick reference. All HNS fee schedules are located on the secure portion of the HNS website: www.HealthNetworkSolutions.net.
2. The new fee schedule was effective **October 1, 2009**. Claims for dates of service prior to 10/01/09 will continue to be adjudicated at the global rate of \$45.00. Claims for dates of service on or after 10/01/09 will be adjudicated per the new fee-for-service fee schedule.
3. Claims run-out period: **All primary claims for dates of service prior to October 1, 2009 must be submitted through HNS no later than October 20, 2009**. Primary claims submitted after October 20 for dates of service prior to October 1, 2009 will not be processed so please make sure to send all such claims to HNS prior to October 20, 2009.
4. **TIMELY FILING**. All primary claims must be submitted for adjudication **within 6 months from the date of service or the claim will be denied**. (For coordination of benefits - claims will be considered based on the primary carrier's processing date stated on the EOB.)

We want to make sure you are paid for ALL services you provide, so please remember that CIGNA HealthCare will not reimburse you for any services other than those listed on the new CIGNA fee schedule.

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What to Do about PI Claims?

Important BCBSNC Announcement

(North Carolina Providers Only)

Per BCBSNC Policy: Claims for ALL covered services, provided to any patient whose insurance is processed by HNS, must be submitted to HNS for processing. This includes claims for all services regardless of the amount of the copayment/deductible and/or coinsurance and regardless of the wishes of the member. *HNS participating providers are contractually required to file claims for ALL covered services. Obtaining a signed waiver from the member does not negate the contractual responsibility of the provider to file claims for all covered services provided.*

Please be aware that this policy *includes Personal Injury (PI) patients who have health insurance.* If a PI patient wants you to file claims to a third party payor, you must remind the patient that **as a participating provider with their health care plan, you are contractually required to file their claims to their health care plan.**

For settlement purposes, or to collect copayments, coinsurance and/or deductibles, claims may also be filed with a third party payor. However, you may not collect or keep any monies in excess of the allowed amount from the health insurance company regardless of monies received from any third party payor.

If you have any questions about this payor policy, please contact your HNS Provider Rep and she will be happy to assist you.

*The Provider Instruction Manual has been updated.
Please visit our web site to print the new manual.*

www.HealthNetworkSolutions.net

GREAT NEWS ABOUT MAINTENANCE CARE

Important Announcement for North Carolina providers in and around Cary, NC!

BCBSNC has recently informed HNS that maintenance/supportive care for the self-funded ASO group, **Town of Cary**, will be a covered benefit. *If you are treating employees of the Town of Cary, you are now free to provide maintenance and supportive care!*

At this time, there are no other BCBSNC self-funded (ASO) groups whose chiropractic coverage includes maintenance and supportive care.

CHIROPRACTIC BUSINESS STRATEGIES MAY LEAD TO JAIL TIME

By Mario Fucinari DC, CCSP, MCS-P

The economy has led many of our patients to have to choose between paying for their chiropractic care and making the house payment. To keep up with competition and to maintain a patient base, some chiropractors have resorted to giving incentives in order to attract new patients and to keep the existing ones. These practices include giving discounts on services or waiving the copayments and deductibles.

The legality of waiving copayments and/or deductibles has been addressed by the government for the last 15 years. In 1994, the Office of Inspector General (OIG) issued a Special Fraud Alert on Routine Waiver of Copayments or Deductibles under Medicare Part B. See, 59 F.R. 242 (1994). In this fraud alert, the OIG advised that: Routine waiver of deductibles and copayments by charge-based providers, practitioners or suppliers is unlawful because it results in (1) false claims, (2) violations of the anti-kickback statute, and (3) excessive utilization of items and services paid for by Medicare. The OIG addressed its concern with routine waiver of copayments and deductibles in its Compliance Program Guidance for Individual and Small Group Physician Practices published on October 5, 2000 (65 F.R. 9434). The OIG stated that: Remuneration for referrals [such as routine waiver of copayments and deductibles] is illegal because it can distort medical decision-making, cause overutilization of services or supplies, increase costs to Federal health care programs, and result in unfair competition by shutting out competitors who are unwilling to pay it. Remuneration for referrals can also affect the quality of patient care by encouraging physicians to order service or supplies based on profit rather than the patient's best medical interests. See, 65 F.R. 59440. In the area of waiver of copayments and deductibles, the Government has been consistently concerned with false claims and violations of the anti-kickback laws.

FALSE CLAIMS ACT

The government believes that a physician who waives copayments or deductibles is misstating or distorting their actual charge. For example, if a physician claims that their charge for a service is \$100 and waives the 20% copayment, the government believes that the provider's actual charge is \$80. **Therefore, a provider who submits a claim for which it has waived the copayment or deductible may be submitting a false claim and may be subject to criminal sanctions under 42 U.S.C. 1320a-7b of a maximum fine of \$25,000, imprisonment of up to five years, or both.** Additionally, a conviction would lead to automatic exclusion from all federal health care programs. The Government can also proceed under the Civil False Claims Act (31 USC 3729-3733) against a provider who waives copayments and deductibles on Federal health care program claims. Furthermore, a dual-fee system is illegal not only under Federal law, but also under most state statutes. Box 31 of the 1500 Health Claim Form is signed by the physician certifying, under penalty of perjury and civil money penalties, that the facts stated on the claim form are true.

Violations of the Civil False Claims Act include fines of up to \$11,000 for each false claim submitted, plus up to three times the amount unlawfully claimed. A provider who violates this Act is also subject to possible exclusion from Federal health care programs.

KICKBACK VIOLATIONS

When physicians waive copayments or deductibles, they may be unlawfully “inducing” the patient to purchase items or services in violation of the anti-kickback statute’s regulations pertaining to the act of offering or paying something of value as an inducement to generate business payable by a federal health care program. An item of value is anything of \$10 value or less *and* no more than \$50 total per year in the aggregate.

The anti-kickback statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce referrals of items or services reimbursable by Federal health care programs. 42 U.S.C. 1320a-7b(b). **Violation of the criminal anti-kickback statute can lead to a felony conviction punishable by a maximum fine of \$25,000, imprisonment of up to five years, or both.** A conviction can also lead to exclusion from federal health care programs. The Government can also choose to proceed civilly for giving a service for free or for other than fair market value. The Civil Monetary Penalties Law prohibits a provider from offering remuneration to a Medicare or Medicaid beneficiary, which the provider knows or should know, is likely to influence the beneficiary to obtain items or services billed to Medicare or Medicaid from a particular provider. The penalty for violation of this law is a fine of up to \$10,000 per item or service, and up to three times the amount claimed. The Government can also seek to exclude the provider from Federal health care programs.

For the above reasons, the physician should also be wary of advertisements that offer services for free or for other than fair market value. These may be in violation of the Anti-Kickback Statute, Gifts and Inducements Regulations and the False Claims Act. In addition, many PPO contracts also forbid this activity.

PERMISSIBLE WAIVERS OF COPAYMENTS AND DEDUCTIBLES

In certain instances, waivers of copayments and deductibles may not be illegal. There are certain circumstances in which the Government will permit the waiver. Each patient’s case must be reviewed individually and the waiver must fit the following criteria:

- (1) The waiver is not offered as part of any advertisement or solicitation;
- (2) The person making the waiver does not routinely waive the amounts; and,
- (3) The person making the waiver: (a) determines in good faith that the individual is in financial need; or (b) fails to collect after making reasonable collection efforts. 42 U.S.C. 1320a-7a.

In the past, the American Chiropractic Association has even gone so far as to state that hardship cases should be determined by first reviewing the tax returns for individuals to verify that their income is below the poverty level for the locality. Routinely waiving copayments and deductibles is never appropriate. Providers should maintain documentation of the need for a waiver in their files.

Marketing strategies and practice management techniques must be carefully monitored for compliance. Actions of waiving deductibles and co-payments or giving services for free or for other than fair market value may yield legal trouble for practitioners.

Mario Fucinari DC, CCSP, MCS-P is a Certified Insurance Consultant through Logan College of Chiropractic and a Certified Medical Compliance Specialist (MCS-P). He is in full-time practice in Decatur, IL. Dr. Fucinari is available for compliance consulting. To contact Dr. Fucinari for documentation, compliance and Medicare continuing education courses, he may be contacted at Doc@AskMario.com

EMG's and Nerve Conduction Studies (Important BCBS Reminder)

ONLY chiropractors who are *Diplomates of the American Chiropractic Neurology Board (DACNB)* can perform nerve conduction studies and EMG's for BCBS members (provided that such services are covered by the member's health plan.)

BCBSNC recently notified HNS that many of our providers are not complying with BCBSNC Corporate Medical Policy regarding EMG's and Nerve Conduction Studies. In February of 2009, HNS announced the updated *EMG and Nerve Conduction Policy*. This information was also included in our 2009 first quarter newsletter, added to the *HNS Provider Instruction Manual* and the *HNS Practice Protection Plan*, as well as the "What's New" section of our website.

If you have received payments for these services and you are not a Diplomat of the ACNB, BCBSNC will be recouping ALL monies paid to you for these services. Also, please be aware that failing to adhere to BCBS Corporate Medical Policy makes you a likely target for BCBSNC post payment audits.

In order to bill BCBS for Nerve Conduction Studies and EMG's, your name must be included on the list of certified chiropractic neurologists on the **ACNB website** (www.acnb.org). (If you are a DACNB and your name does not appear on this website, please contact the ACNB immediately. Request that they update the website to include your name and status so that you may provide and bill for these services.)

There are currently only three HNS providers listed on the ACNB website and as such, these three providers are the **only HNS network providers eligible** to bill BCBS for EMG's and Nerve Conduction Studies.

**Dr. Thomas Ahart
Dr. Mark Pustaver
Dr. Michael Trayford**

So please remember, unless you are one of these three network providers, **you cannot bill for EMG's or Nerve Conduction Studies for BCBS members.**

**To stay *In the Know...*
check out the "What's New" section
of our website at:
www.HealthNetworkSolutions.net**

HNS Network News



Billing News

Quarter 3, 2009

Announcing a **NEW** Feature for HNSConnect

...to reduce your denials and save you time!

*“Oops, I’ve already sent that claim. Can I delete it?”
“Why are there so many duplicate denials on my EOB?”*

Sound familiar? Asked these questions before? If so, you are not alone and we are pleased to announce a new feature on *HNSConnect*, **DUPLICATE CLAIM EDIT**, which will eliminate the need for these questions.

As part of our ongoing commitment to offer unparalleled electronic solutions, we have added a new feature to *HNSConnect*, our electronic claims filing system. Effective **October 12, 2009**, *HNSConnect* (formerly ChiroTrack) will notify you when a previously submitted claim is received. These claims will error back with a message indicating that the claim is a duplicate and should not be resubmitted. The claims filing process is a challenge; and inadvertently submitting claims that were previously submitted to the payors for adjudication takes time to undo.

The **Duplicate Claim Edit** feature is designed to enhance your office productivity by alerting you that a claim has been previously submitted to the payor for adjudication. This new feature will assist as follows:

- Prompt you to verify the original submission of the claim.
- Save you time by not waiting for payment or EOB only to find the claim will not adjudicate for payment because of a previous submission.
- Reduce the number of refunds to payors as a result of receiving duplicate payments.

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Remember, if a claim rejects as a “duplicate” on *HNSConnect*, it has been previously submitted *electronically*. If you have not received payment for the claim, the first step is to research the status of the claim. To begin your claim status research, ask yourself the following questions.

- Q: Do I have claims with errors on *HNSConnect* that need to be corrected?
A: If yes, correct or delete your claims with errors in order to resubmit the claim with the correct information.
- Q: Have I received a ‘HNS Electronic Claim Error Report’ for this patient?
A: If yes, correct the claim for the reason given in the error report and resubmit the claim with the correct information through *HNSConnect*.
- Q: I found no errors or rejections, what do I do now?
A: Use your ‘**HNS Fax Inquiry Form**’ and fax the necessary information to your HNS Provider Rep and she will gladly assist in researching the claim status.

This new feature will check each claim submitted electronically to HNS to determine if it matches a previously submitted claim. To determine if a **CLAIM IS A DUPLICATE**, *HNSConnect* checks certain fields on the CMS 1500 form. We have included a listing of these fields on our website at www.healthnetworksolutions.net located in the ‘HNSConnect Instruction Manual.’ Please keep this information handy so you can refer to it as needed.

We hope this new edit will **reduce denials and save time**. As always, we are here to help. Please call us if you have any questions about this new enhancement at (877) 426-2411 or fax an inquiry to (877) 329-2620.

HNS has updated the Provider Instruction Manual.

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www.HealthNetworkSolutions.net

to view the updated manual.

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Important Announcement for North Carolina providers in and around Cary, NC!

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At this time, there are no other BCBSNC self-funded (ASO) groups whose chiropractic coverage includes maintenance and supportive care.

Medicare Cross Over Claims (Secondary Claims)

In order for any secondary claims to adjudicate, the provider must generate a new claim, attach the primary EOB and file both of these (secondary claim and primary EOB) to the secondary payor. If the secondary claim is for a HNS contracted payor, the claim and EOB must be processed through HNS.

For BCBSNC claims, when BCBS is secondary to Medicare, Medicare automatically sends the claim electronically to BCBSNC. This is referred to as Medicare Crossover.

In such cases, BCBSNC receives your secondary claim (with the Medicare EOB information) directly from Medicare and these “crossover claims” do not include the required electronic HNS signature that alerts BCBSNC that you are a participating provider. This unique HNS signature is electronically placed on the claim after it is received at HNS *and is required for proper adjudication of all claims, including secondary claims*, so that BCBSNC recognizes you as an “in-network” provider. Therefore, when Medicare claims electronically crossover to BCBSNC, the BCBSNC systems deny those claim with the remark/reason “must file chiropractic claim through HNS.”

Please note that this is not a new scenario and has always occurred with Medicare Crossover claims when BCBS is secondary. Once a network provider receives the Medicare EOB, they are instructed to generate a new claim form to send to the secondary payor (just as you do with all secondary claims), attach the Medicare EOB, and send both to HNS. The claim is then electronically “signed” by HNS and the claim is submitted to BCBSNC. These claims are then correctly adjudicated by BCBSNC.

BCBSNC has experienced some internal system problems over the last few months that have resulted in the **incorrect adjudication** of some, but not all, of these claims. This BCBSNC system problem has resulted in the following three scenarios:

1. The secondary claim with the primary EOB attached has incorrectly denied as a duplicate claim.
2. The BCBS system has paid the provider twice for the same date of service; first when Medicare crossed over the claim, and again when the provider correctly resubmitted the claim through HNS.
3. The BCBS system has paid the patient directly, rather than paying the provider.

BCBS is working diligently to resolve this problem as quickly as possible. Most of these claims have now been correctly adjudicated and they are working to assist us with resolving any outstanding secondary claims that were incorrectly adjudicated.

If you have any claims that have incorrectly adjudicated as a result of this issue, please contact your HNS Provider Representative for assistance.

What to Do about PI Claims?

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(North Carolina Providers Only)

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Please be aware that this policy *includes Personal Injury (PI) patients who have health insurance.* If a PI patient wants you to file claims to a third party payor, you must remind the patient that **as a participating provider with their health care plan, you are contractually required to file their claims to their health care plan.**

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Practice Information Changes

(Help patients locate you)

All HNS contracted payors strive to keep the most up-to-date information on all their participating providers. They use **provider and practice change information** to update their provider directories, which helps patients locate you when searching for an in-network provider.

We are contractually required to update our payors with provider or practice changes **every 15 days** and for this reason, network providers are contractually required to notify HNS of ANY change to your practice information within 15 days of the date of the change. We are also required to send our payors a detailed listing, EACH MONTH, of every provider in the network, together with current practice information.

Network providers must send HNS all provider and/or practice information changes as quickly as they occur. Please help by always keeping us informed of these changes.

Contact your HNS Provider Representative if there is ANY change to your practice information. We promise it will be quick and painless...

Tip for Verifying Eligibility and Benefits

When verifying benefits with the payor phone representative, always document ALL information obtained. In addition to benefit information, obtain and document the following:

1. The name of the person who quoted the benefits.
2. A reference number for the conversation, if available.
3. The date and time of the conversation.

The payor phone representatives do not always have access to corporate medical policies and occasionally give incorrect benefit information. By documenting this information on your patient's **Insurance Verification Form**, you will be able to accurately reference the information obtained from the payor. Having this information in writing can be very important should a controversy arise regarding a covered benefit.

PLEASE REMEMBER: Regardless of what you may be told by the payor representatives, **the payor corporate medical policies always supersede any information you may receive when verifying eligibility and benefits.**

Inclusive Health Claims

North Carolina Providers Only

All Inclusive Health claims must be submitted to HNS via “paper claims” using the CMS 1500 claim form.

Inclusive Health CANNOT PROCESS chiropractic claims that are not sent through HNS. In order to get your claims adjudicated quickly, **submit them to HNS by paper** and we will forward to CoreSource, the administrator for Inclusive Health, for adjudication.

Currently, Inclusive Health claims cannot be submitted electronically to HNS via *HNSConnect* (formerly *ChiroTrack*.) We anticipate that you will be able to submit these claims electronically through *HNSConnect* within a few months and will keep you informed as this option becomes available.

If your office has a question on whether a claim is filed through HNS, use the new ‘**HNS Fax Inquiry Form**’ and send a clear, legible copy of the member ID card to your HNS Provider Rep for clarification and we will respond quickly!

CLICK HERE to find out more information about Inclusive Health.

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Current News

Quarter 3, 2009

Save The Date!!!

April 16, 17, & 18

HNS Free CE Seminar

Our Free CE Seminar for **2010** is scheduled for **April 16, 17, and 18**, so please mark your calendars now and...

SAVE THE DATE!

Dr. Art Croft will be presenting the final module of his program for certification in Brain Injury Traumatology. Additionally, to assist you with meeting the new NC BOE CE requirements, our 2010 CE Seminar will also be offering 6 hours of CE on Documentation, Coding and Compliance, as well as 6 hours on Ethics and Professional Boundaries.

So please take a moment to **save this date** on your 2010 calendar! We look forward to seeing you at the CE seminar and the **HNS Cocktail Reception** on Saturday night, April 17th.

FREE ONLINE CONTINUING EDUCATION!

4 New CE Hours Available online

The continuing education course "Documentation, Coding and Compliance for Proper Reimbursement," presented by Dr. Mario Fucinari, is now available FREE on the secure section of our website at www.healthnetworksolutions.net.

Dr. Mario Fucinari, a well-known NCMIC speaker and consultant for chiropractic documentation and billing procedures, provides an excellent program on documentation, coding, and compliance.

The 4 hour continuing education web seminar is approved for CE credits by both the NC BOE and the SC BOE. After passing the 10 question quiz, an email will be sent to you (and to HNS) confirming your 4 CE credit hours. On your behalf, HNS will report those earned credit hours to your state Chiropractic Board of Examiners.

If you have any questions regarding Dr. Fucinari's seminar, please contact your HNS Provider Representative for assistance.

RED FLAG RULES

All Providers Must Comply

Deadline Delayed until November 1, 2009

To give creditors (physicians) and financial institutions more time to review the Red Flag Rules and to develop and implement the required written Identity Theft Prevention Programs, the FTC has delayed the enforcement of the rule until November 1, 2009.

To assist you with compliance to this new ruling, a template for your Red Flag Policy was sent to all HNS providers in the June 30, 2009 check cut packet.

If you need another copy of the policy, contact your HNS Provider Representative for assistance.

WANT TO INCREASE YOUR MEDICARE REIMBURSEMENT?

NCQA Back Pain Recognition Programs (BPRP) Approved by Medicare Physicians Quality Reporting Initiative for 2009

The Centers for Medicare & Medicaid Services (CMS) has accepted the Back Pain Recognition Program for measuring group reporting for the purposes of the Physician Quality Reporting Initiative (PQRI). Physicians, chiropractors and nurse practitioners who have earned BPRP Recognition from the NCQA now have the opportunity to enjoy an extra benefit: they may opt to have NCQA submit their clinical quality data to Medicare for use in the PQRI.

Providers participating in Medicare's PQRI program receive financial rewards for collecting and reporting practice data about the quality of their care. **In 2008, that reward was equal to 1.5 percent of each Medicare FFS Part B claim; in 2009 it rose to 2 percent.**

Ways to join:

1. For BPRP Recognized providers: Clinicians, who are already recognized by NCQA, would have to submit their qualifying data from the 2009 reporting period to receive PQRI incentive payments. In addition, each clinician must provide NCQA with a written authorization that his/her data can be shared with CMS. 30 patients rather than the 25 necessary for Recognition are required in the submittal, and data must be submitted on at least 2 Medicare Fee for Service patients. The submission fee is \$150 (per clinician) for resubmitting data for PQRI.

2. For providers currently applying for or considering applying for NCQA's BPRP program: Eligible providers should submit to NCQA their Recognition Program application along with a written authorization from each clinician that his/her data can be shared with CMS. 30 patients rather than the 25 necessary for Recognition are required in the submittal, and data must be submitted on at least 2 Medicare Fee for Service patients. NCQA is providing clinicians with this opportunity to qualify for the 2009 PQRI registry as an added feature to the Recognition process.

"Physicians and others who participate in PQRI through NCQA Recognition enjoy the two-fold benefit of being recognized for superb care, as well as being rewarded by Medicare for reporting clinical data," said NCQA President Margaret E. O'Kane.

For more information, including instructions and frequently asked questions, visit NCQA Web site at www.ncqa.org/Recognition.

News Release:
Posted October 2, 2009

ACA's Efforts to Restore DC Physician Status in Federal Health Plan Successful

(Arlington, Va.) After months of intensive negotiations between the American Chiropractic Association (ACA) and Blue Cross Blue Shield Association (BCBSA), doctors of chiropractic are once again designated as “physicians” in the BCBSA Federal Employee Plan (FEP), the world’s largest health plan and one that President Obama has identified as a template for future health care reform. The 2010 FEP benefits brochure confirms the change.

“We are pleased to report that doctors of chiropractic are in the physician category under the Blue Cross Blue Shield Federal Employees Benefit Plan, limited only by state scope of practice authorization,” said ACA President Rick McMichael, DC. “The agreement culminates months of negotiations between the ACA and BCBSA and assures that a doctor of chiropractic will be identified and defined as a ‘physician’ in the FEP. This plan has been specifically and repeatedly identified by Congress and President Obama as the template for coverage and recognition in national health care reform. Physician status under this health plan is critical, and ACA action has assured that this status is once again recognized.”

“We believe this action will be viewed by future doctors of chiropractic as a landmark development in the history of this profession, assuring our rightful role as physicians in the national health care system,” Dr. McMichael continued. “Our hats are off to ACA’s Immediate Past President Dr. Glenn Manceaux and past Chairman of the Board Dr. John Gentile, who led the ACA team’s charge in this effort. We call now on all doctors of chiropractic to join us in the battles that still lie ahead.”

It was in January of this year that BCBSA changed the designation of doctors of chiropractic from “physicians” to “other health care providers.” ACA immediately recognized that the change could have a serious impact on whether DCs would be allowed to provide the physician-level services they are educated and licensed to perform—and could even influence whether chiropractic care would be restricted or completely excluded in a national health care plan using the FEP as a model. ACA promptly contacted BCBSA and requested that the designation be reversed.

While BCBSA stated that the change would not affect benefits, some plans apparently misinterpreted the intent of the change and have restricted services such as examinations, X-rays and therapeutic modalities. In addition, some DCs have been prohibited from referring FEP patients for other services, including diagnostic and physical and occupational therapy services. DCs who are still encountering these problems under the FEP should contact the ACA Insurance Relations Department at Insinfo@acatoday.org.

The BCBSA FEP is the largest privately underwritten health insurance contract in the world, enrolling 4 million federal government employees, dependents and retirees.

The American Chiropractic Association is the nation’s leading chiropractic organization representing more than 15,000 doctors of chiropractic and their patients.

EMG's and Nerve Conduction Studies (Important BCBS Reminder)

ONLY chiropractors who are *Diplomates of the American Chiropractic Neurology Board (DACNB)* can perform nerve conduction studies and EMG's for BCBS members (provided that such services are covered by the member's health plan.)

BCBSNC recently notified HNS that many of our providers are not complying with BCBSNC Corporate Medical Policy regarding EMG's and Nerve Conduction Studies. In February of 2009, HNS announced the updated *EMG and Nerve Conduction Policy*. This information was also included in our 2009 first quarter newsletter, added to the *HNS Provider Instruction Manual* and the *HNS Practice Protection Plan*, as well as the "What's New" section of our website.

If you have received payments for these services and you are not a Diplomat of the ACNB, BCBSNC will be recouping ALL monies paid to you for these services. Also, please be aware that failing to adhere to BCBS Corporate Medical Policy makes you a likely target for BCBSNC post payment audits.

In order to bill BCBS for Nerve Conduction Studies and EMG's, your name must be included on the list of certified chiropractic neurologists on the **ACNB website** (www.acnb.org). (If you are a DACNB and your name does not appear on this website, please contact the ACNB immediately. Request that they update the website to include your name and status so that you may provide and bill for these services.)

There are currently only three HNS providers listed on the ACNB website and as such, these three providers are the **only HNS network providers eligible** to bill BCBS for EMG's and Nerve Conduction Studies.

**Dr. Thomas Ahart
Dr. Mark Pustaver
Dr. Michael Trayford**

So please remember, unless you are one of these three network providers, **you cannot bill for EMG's or Nerve Conduction Studies for BCBS members.**

**To stay *In the Know...*
check out the "What's New" section
of our website at:**

www.healthnetworksolutions.net