
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.

"Quality is never an accident...

*It is always the result of high intention,
sincere effort,
intelligent direction,
and skillful execution.*

It represents the wise choice of many alternatives."

~Will Foster

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.

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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**