Fall 2008

CB&C NEWS

YOUR CHIROPRACTIC OFFICE SPECIALISTS!

Volume 4, Issue 1

Horizon BC/BS - What now?

Are you a Horizon BC/BS ***non***–participating provider? Are physical therapy and modality CPT codes (the '97' codes) and exams provided to your patients? Do you have patients insured by BC/BS carriers ***other*** than Horizon BC/BS (eg - Empire BC/BS, Highmark BC/BS, Anthem BC/BS, etc.)? If you answered yes to these questions, we encourage you to closer evaluate these patient's EOBs for processing errors.

Most of you are aware of the Horizon BC/BS policy regarding non-payment of the '97' codes and exams. However, chiropractors often don't realize that this policy is NOT common to all BC/BS carriers. As a matter of fact, many other BC/BS carriers including those listed above DO cover exams and '97' CPT codes when rendered by a Chiropractor (dependent on that carrier's guidelines and the insured's policy). That said however, these services are often denied when billed for these patients by Chiropractors in New Jersey. Why?

To understand what is happening you first need to understand the claim submission process for all BC/BS patients. Horizon BC/BS is the BC/BS carrier for New Jersey (the 'local plan'). There are many other BC/BS carriers servicing states across the country (the 'home plans'). Participating AND non participating providers are required to submit claims for all BC/BS patients to the 'local plan'. This process allows Horizon BC/BS to advise the 'home plan' on whether the provider is participating or not. In this fashion, Horizon BC/BS is able to dictate how the claim should be paid for participating providers (applying Horizon BC/BS fees & contract guidelines). If a provider attempts to bypass Horizon BC/BS and submit the claim directly to a 'home plan', the claim is usually denied or returned stating 'claim must be submitted to the local carrier'.

This requirement (for this purpose) seems reasonable relative to Horizon BC/BS **participating** providers as they have signed a contract to accept Horizon BC/BS chiropractic policies and fee schedule. It only becomes unreasonable when Horizon BC/BS also dictates how **non-participating** providers should be paid. Remember non-participating providers have NO signed contract binding them to accept Horizon BC/BS policies and fee schedule. Shouldn't it then be simple that reimbursement for BC/BS patients *continued on page 4*

BRINGING OUR EXPERIENCES TO YOU

Points of interest inside newsletter:

?? Did you know ??

UHC does not cover 97124, 97014, 97010—you may want to read up on the 'G' codes as a replacement to 97014

Aetna's New PIP Program

If you are an Aetna participating provider you may have received notification regarding their new PIP Program. You can contact them to explore the issue more thoroughly and evaluate the pros & cons of participating with this program.

One question to explore would be whether this will increase patient volume. Will patients be *directed* to your office for care that you would NOT have seen otherwise? If so, how? What is the fee schedule that will apply? As you know there is already a NJ PIP fee schedule. If you participate then you are already familiar with Aetna's fee schedule for health insurance . If the same Aetna fee schedule applies, is that a loss you are willing to take on your PIP patients?

If you decide the program is not beneficial to you and your office, you should have a choice to opt out of the Aetna PIP program and still retain your Aetna participating provider status.

NJ Has a New Medicare Carrier

National Government Services (a local Medicare carrier) will no longer be servicing NJ effective 11/14/08. All NJ Medicare dealings will be handled through Highmark Medicare Services as of that date.

Therefore Highmark Medicare Services is requiring all providers that were set up on EFT to again complete a new EFT Authorization Agreement. This allows funds to be directly deposited into the provider's bank account instead of receiving paper checks via mail. If you received an EFT form but you were NOT on EFT previously you can continue to receive paper checks. However, if you make any changes to your practice information in the future, Medicare will then force you to enroll in EFT. If you still wish to receive paper remittances once enrolled in EFT, make sure you include a letter to that effect with the EFT form.

Managed Care Contracting Affecting 'Out of Network' Payments

For those of you that have heard this information from us before, bare with this repeat!. We will not be satisfied until every reader understands this situation which is affecting so many out of network providers. So let's begin with the question that providers contemplate ever day — *Should I be a participating provider or a non-participating provider* ?

The deciding factor is often the fee schedule applied to in-network claims. Many providers will not consider these low fee schedules fair reimbursement for the service provided to their patients. That being said 'fee schedule reductions' should ONLY be applicable to participating providers—right? WRONG! The fact is payments are being reduced for 'fee schedule reductions' but are still processing out of network (meaning deductibles and coinsurances). The question is how is this happening, when did this start happening, and do providers even realize if it is happening to them? Let's start by reviewing how providers balance the 'scale' of participation:

The negatives:

*Provider is obligated to accept a substantially lower fee schedule than the provider's billed charges

The positives:

*Provider is 'in book' / 'on the list'

*Potential higher patient volume

*Can receive in-network referrals

* In-network copays vs higher deductibles / coinsurances

If a provider feels that the positives are not enough to accept the negative, the provider will remain a non participating provider. Therefore, the provider should expect to be paid at 'reasonable & customary'. This means that basically the amount billed should be the same as the amount allowed on the EOB(as long as providers fees ARE reasonable and customary).

Therefore why do so many EOBs for out of network providers have a billed amount but then a different ALLOWED amount. This may very well be because the insurance carrier has a contract with a 'managed care company' that the provider also has a contract with and therefore the carrier holds the provider to that fee schedule. But because the provider does not have a one-on-one contract with the carrier, the provider is still out of network. Basically in looking at the scale above, even though the provider's reimbursement is negatively reduced to a fee schedule, the positives listed above do NOT apply!

You may be asking the same question we did when we first starting seeing this happen 5 years ago—how is this possible? It is possible because providers signed contracts with 'managed care companies' (such as Mutliplan, PHCS, Beech Street, PPO Next, Mastercare, Devon, etc.) years ago when it was thought that the best thing to do for your practice was to participate with everything possible. Those signed contracts that seemed irrelevant are now very relevant. Before you kick yourself for signing these contracts years ago, remember that at the time you signed these contracts this was not the intended use.

Unfortunately, carriers like Aetna, Cigna, United Healthcare, Oxford (and so many others) are contracting with as many of these managed care companies as possible. When an out of network claim is received they search the tax ID# to find any of these contracts so they can assign the fee schedules yet still process the claim at the out of network benefit.

Where is the balance of the 'scale' now:

The negatives:

* Obligated to accept the fee schedule

* Provider is not in book or on the list

* High deductibles and coins still apply

The positives:

* ??????????????

If you evaluate your EOBs and find such reductions what should you do? You may have to actually do a little detective work to find the original contract. Many of these managed care carriers have been bought and sold and/or changed names. They also often lease contracts to each other, etc. Once you have found the origin of the contract, you need to decide whether you should remain in network. Weigh the pros and cons. What are the positives to continue with this contract? If you are basically still out of network, what positive impact will it have to balance the negative of the fee schedule reimbursement.

If you decide to terminate the contract, send a letter to the managed care company. Make sure your letter includes the managed care company and all affiliates (for example, PPO Next, Beech St, & Viant are all affiliated). If you only terminate one, you may then may get pulled back in through the affiliates. Demand a letter back from the company with your official termination date. Lastly, keep checking your EOBs regularly for new reductions. We have seen time and time again that a provider terminates one contract but then the carrier finds the tax ID# linked to another managed care company and reductions will then be made based on that contract. Keep on top of this vicious cycle.

Chiropractic / Physical Therapy Offices and Medicare Changes 2008

If you are not already aware, the cap for Physical Therapy has increased from $1780 to $1810 per year effective 2008. That is the good news. The bad news is that effective 7/1/08 Medicare is no longer recognizing the 'KX' modifier for services billed by physical therapists under the Medicare Part B benefits. This modifier was used when submitting claims to inform Medicare that the patient's condition and treatment would exceed the cap allowance and should qualify for an exception.

We contacted Medicare to question what should be done when a patient's care will exceed the cap allowance. They offered the following two options.

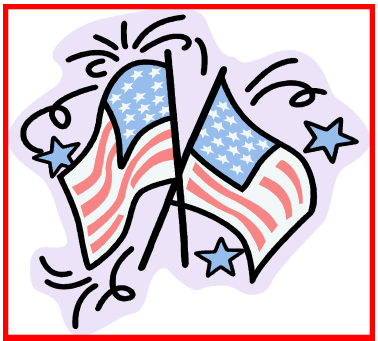
1) Have the patient sign an ABN notice that informs them their care may be denied due to exceeding the allowance cap. In this way you can use the 'GA' modifier on the claim submission and if the claim is denied stating the maximum has been met, the claim should deny with a "PR" denial which indicates 'patient responsibility'. This will allow the provider to balance bill the secondary (if applicable) or to bill the patient directly.

2) Send the patient to a facility in which the patient can use their outpatient hospital benefits which is Medicare Part A.

The following is a link for providers to read further on this new change. This link in particular will take you to the website of National Government Services (one of the Medicare Carriers). From there you can use the hyperlinks to move to the actual CMS website to view their published information as well: www.ngsmedicare.com/NGSMedicare/PartB/NewsandPublications/WhatsNew/PartBNews08/ngs_070308_pe200807-03.aspx

Here is another link we found to a page of a website that notifies patients of the change:

http://www.medicare.gov/Publications/Pubs/pdf/10988.pdf



Happy Labor Day!!!!

CB&C would like to acknowledge everyone involved in the 98943 again being a service that Chiropractors can give to their patients!

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CB&C Issue Quote:
'Ability is what you are capable of doing. Motivation determines what you do. Attitude determines how well you do it.' .....Lou Holtz

Come visit us at the ANJC Convention November 1st & 2nd

The Benefits of NCV Testing in YOUR Office

For the past two years, I have been utilizing in-office Neuro Diagnostic testing (NCV's-Nerve Conductivity Velocity Testing). Information generated by this test is specific for ruling in or out certain conditions and has been extremely useful in the clinical assessment of my patients. You may wonder, what does the test actually measure & how does it benefit patients.

The test is looking at three aspects of the nerve. First it measures the time taken for the nerve to fire after stimulated. Second it measures the velocity of the nerve conduction (how fast the nerve is traveling). Lastly, the test measures what percentages of the nerve fibers are working. The test is so specific that it can determine, not only if there is slowing of the nerve, but also precisely where the nerve is being compromised. Through interpretation of the test, we can also localize specific injury site, establish a prognosis for recovery, and estimate a time frame for nerve healing.

So how does this information help in the diagnosis & treatment of the patient? Here's an example of one of my patients. A 35 year old man was complaining of pain & abnormal sensations traveling from his neck into his left shoulder down into his upper arm, lower arm and though the wrist. After a clinical trial of adjustments, the neck and upper arm pain greatly improved, however the paresthesias into the lower arm and wrist persisted. The MRI showed no compression on the nerve root so I performed an upper extremity NCV. The results showed a moderate to sever axonal type injury to the ulnar nerve with primary injury site at the elbow. The patient further explained that 1 month prior he crashed on his mountain bike and injured his left elbow. After clearing the cervical spine I started adjusting the elbow. The patient is now symptom free. I was able to submit the test to the insurance company for reimbursement. I am so excited about the information generated from this test that I am now doing the testing at other doctor's offices so their patients can also benefit from NCV testing.

In closing, providers should understand that this test offers great clinical information in assessing treatment plans and will assist the provider in proving clinical necessity if a patient's chiropractic care if being questioned by a carrier. Lastly, the NCV Testing is reimbursed by the insurance carriers. If you would like more information about these services or are interested in having them performed in your office, I welcome you to contact me at 973-595-7555. Guy Margolin, DC

Horizon BC/BS, continued…

insured by other carriers be determined by the policy that the patient holds and the guidelines of that specific carrier?

In contacting BC/BS carriers to question when such services are denied, the problem appears to be in the manner in which Horizon BC/BS is forwarding the claims to the 'home plans'. Therefore the resolution to this problem seems simple enough. When Horizon BC/BS receives a claim for a member insured by a BC/BS carrier (other than Horizon) from a non-participating provider, the claim should be forward on simply indicating: *This is not a Horizon BC/BS participating provider. We are unable to dictate how the claim should be processed. Please process per the carrier's policies and guidelines.*

In closing, this issue can be summed up by simply saying - If there is ***no*** signed contract between non participating providers & Horizon BC/BS the ***only*** function BC/BS should have in claim processing is to indicate such and pass the claim through to the 'home plan'.

For more information regarding this issue, please contact us at the info below.

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