ChiroTalk

An Email update by ChiroCode Institute and DH Leavitt
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HIPAA UPDATES
HIPAA MYTHS AND REALITIES
ADVANCE BENFICIARY NOTICE (ABN) - UPDATE
ABN & MODIFIERS
ABN APPEALS
NEW QUICK QUESTIONS

HIPAA UPDATES
Last month we reported: "most offices doing paper claims are EXEMPT from HIPAA," but we keep getting calls asking, "are you sure that we are HIPAA exempt if we don't do electronic transactions?" YES, It is absolutely true! The new HIPAA rules for electronic billing, security and privacy do not apply to your office if you do ONLY manual (paper) transactions. **If you do any electronic transactions at all, then you become subject to all of the HIPAA rules and regulations**, including new privacy standards. If you contract with a billing service, then both you and your billing service are subject to HIPAA standards."

An "electronic transaction" according HIPAA includes about 9 basic types (claims, payment, benefit coordination, claim status, enrollment, eligibility, remittance advice, certification, authorizations, etc). An electronic transaction is more than just claims!

Our statement bothered some of our good readers and consultant friends. We got feedback! Some felt that the proposed Security rules would redefine the covered entity determination; e.g. Protected Health Information (PHI) on paper or stored in a computer and printed to paper). We retained legal counsel and spoke with 5 national law firms who are experts on HIPAA. We learned that we were correct in our September statement (above)... even as of and through September 27th 2002. On this date the HIPAA folks restated the rules for a Covered Entity: If you are a Covered Entity, you are then subject to the Electronic Transaction, Privacy and Security Standards. It is NOT the other way around. See and download the HIPAA Sept 27, 2002 for the "who is covered" rules:
http://www.cms.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp

HIPAA MYTHS AND REALITIES

There some good "authorities" who are preaching as fact, that which is pending in the proposed security rules (HIPAA-crap from the HIPAA-crates)--
-That 3 out of 4 legal firms have the opinion that a FAX is not an electronic transaction. Until that dust settles, NON-HIPAA paper offices should avoid FAX transmissions of protected health information (PHI).
-That there is a lot of good stuff in the Privacy Standards that every good ethical office should consider and adopt, even if they are not a HIPAA "covered entity".

Please: If you are doing any HIPAA electronic transactions now, or plan to in the coming year,
1. File your Electronic Transaction extension before October 15, 2002. Here is the site:
http://www.cms.gov/hipaa/hipaa2/ASCAForm.asp
2. Study and start implementing the Privacy rules. Final Compliance deadline is April 14, 2003.
Caution: Don't assume that the MAY means MUST in the rules (e.g. the "consent" notice).

ADVANCE BENFICIARY NOTICE (ABN) - UPDATE

On page A-42 of your *2002 ChiroCode DeskBook* we stated, "During 2002 watch for updated rules on the http://www.cms.gov website.
As you know, an update has happened. A new Advanced Medicare Beneficiary (ABN) notice became effective October 1, 2002. It is known as the Program Memorandum (PM) Transmittal # AB-02-114.
http://cms.hhs.gov/manuals/pm_trans/ab02114.pdf It supercedes all the prior ABN forms and instructions. The new ABN form dated June 2002 is almost the same as the old form dated June 2001 (see sample of the old ABN on page A-43 of your *2002 ChiroCode DeskBook*). The only difference is a few bolded words to make it easier for Medicare patients to read.

What is really different? It is the new instructions for use. Get the new ABN form and instructions from http://cms.gov/medlearn/refabn.asp

Gone are the days of a general disclaimer for all services. The new rule in this PM transmittal Section 1.3 a,1, b states: "If the physician or supplier 'never knows whether or not Medicare will pay', an ABN should not be used". All doctors and consultants who have read the CMS instructions seem to agree that it would be a "rare occasion" (like snow in Phoenix in the summer time) when the ABN form could be used. In summary an ABN is never to be used for:
1. NON-covered services other than 98940-98942 codes. (E/M, x-rays, physio therapies, etc)
2. NON-covered services within the 98940-98942 code set (Maintenance care & stable chronic conditions).
3. Acute care treatment (with a valid diagnosis) because we would expect them to pay.

An ABN can only be used with the 98940-98942 code set when you know or believe that Medicare will not pay. This is also known as the Medical Necessity game. Here are some possible situations and statements for use in the BECAUSE box:
1. You had more than 2 visits (Chiropractic Adjustments/Manipulation Treatments) in one day,
2. Your condition (diagnostic code) is not on the approved list by Medicare. (If you don't have it from your local carrier, get it.)
3. The frequency of visits for your condition exceeds Medicare's guidelines. (Get that one, if you can).
4. Your chronic (persisting) condition is almost stable, and Medicare has not defined 'stability'. (Some local carrier have 3-4 weeks)
5. You were seen by another DC this year for the same condition.

If you have any other possible situations (encounters) that might qualify, please share.
Give us feedback at leavitt@chirocode.com.

ABN & MODIFIERS
They remain the same (as on page A-44 in your *2002 ChiroCode DeskBook*). Append the -GA modifier when you have the signed ABN. Append -GY for Non-covered items or services. Append nothing if you know Medicare is going to pay.
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ABN APPEALS
ChiroCode Institute has appealed to the CMS home office staff to review their instructions. If they expect DCs to give specifics (when they are not going to pay), they must disclose those specifics, so that patients can be properly informed. Failure to do so, is a sinister shift of financial obligation from CMS and patients to the providers (DCs. MDs, and DOs). If their objective is fewer providers and fewer patients, their mission will be accomplished.

NEW QUICK QUESTIONS

We post a new Quick Question weekly at www.chirocode.com. Here are the recently posted Quick Questions:

1. HIPAA Compliance
If I am a provider who does not submit any electronic transactions, do I have to comply with the HIPAA Administrative Simplification regulations or submit an ASCA compliance plan to get an extension?
2. Medicare claim resubmittal
How do I resubmit a Medicare claim for a patient visit that was denied?
3. Cervical Traction--Equipment Rental
What code do I use to bill for Over-The-Door cervical traction which a patient rented for 5 days?
4. House Calls
I want to start doing more house calls. Other than changing the place of service code to "12", is there anything else that I need to be put on the CMS-1500 forms? Also, if a business wants me to treat their employees from an office set up as an exam room at the business, how would I bill? I'm not sure I want to do this if it is too complicated or would get me in trouble.

Answers to these Quick Questions are found on our website, http://www.chirocode.com.

If you have follow-up questions or comments, as always, we'd would love to hear from you!

D H Leavitt, President
leavitt@chirocode.com