

Medicare: Notifying Beneficiaries

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Please be advised that this article is not intended for doctors of chiropractic participating in the Medicare Chiropractic Demonstration Project, which would include doctors in Maine, New Mexico, some parts of Illinois and Virginia, and Scott County in Iowa. Doctors from those areas who have chosen to participate in the project should consult <http://www.acatoday.com/demo> for the proper information and resources relating to them. The information below will still be pertinent to doctors from those areas who are NOT participating in the demonstration project.

The ACA office receives a lot of questions about which forms to use when treating Medicare beneficiaries to notify them that Medicare may not reimburse some of the services. The answer to this question requires some understanding of certain regulations.

Under Medicare, the only covered service for doctors of chiropractic is manual manipulation of the spine to correct a subluxation, and only active care (acute and chronic) is reimbursable. Maintenance care is not reimbursable, although it is still spinal manipulation and, therefore, still a covered service. (For the exact definitions of acute, chronic, and maintenance care, consult the Medicare section of the ACA Chiropractic Coding Solutions Manual or visit <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>, Chapter 15 of the Medicare Benefit Policy Manual, §240.1.3.) **The critical thing to remember is that, just because something is a covered service, it does not necessarily mean it is reimbursable.**

This distinction is important for many reasons but, in terms of patient notification, it is vital to understanding which form to use.

- **For Covered Services (spinal CMT):** If you have reason to think that the treatment of a Medicare beneficiary for a particular treatment date is maintenance care, therefore being considered not medically necessary and not reimbursable by Medicare, you would have the patient sign an Advanced Beneficiary Notice (ABN). This is the form that it used when a normally covered service (spinal manipulation) will be denied due to lack of medical necessity.

Be advised: the proper deliver of an ABN is very formalized and detail-specific. Doctors must use the ABN developed by CMS (CMS-R-131-G). Please Note: Blanket ABNs are not permissible—you may not have a patient sign an ABN one time and then charge them from that day forward for every claim which is not paid by Medicare.

For more information on administering ABNs, you can visit <http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf>, Chapter 30 of the Medicare Claims Processing Manual §50. (Be advised that this section is 20 plus pages and starts on page 41 of the document.) You can also check out the Medicare

section of the ACA Chiropractic Coding Solutions Manual, which has a condensed version of these instructions.

- **For Non-Covered Services (anything that is NOT spinal CMT):** You may have the patient sign a "Notice of Exclusion from Medicare Benefits" (NEMB). This form is optional. You would **never** get an ABN signed for any of these services, because they are not covered services, and an ABN is intended only for covered services.

All forms are available on http://www.cms.hhs.gov/BNI/01_overview.asp#TopOfPage , which is the Centers for Medicare & Medicaid (CMS) website for the Beneficiary Notices Initiative. For more information on the forms and Medicare in general, you can visit www.acatoday.org/medicare.