MYSTIFIED BY MEDICARE?

A Crash Course for Aspiring Private Practitioners

L. Katherine Stewart, MS, CCC-SLP
Afferent Connections Speech Pathology

Learning Objectives

- ★ Explain the Mandatory Claim Submission Rule and its implications for delivery of speech-language pathology services.
- ★ Outline the necessary steps for a provider to apply for Medicare participation.
- ★ Explain Medicare documentation requirements for evaluation reports, plans of care, progress notes, and discharge summaries.
- ★ Briefly describe the process of Medicare claim submission.
- ★ Identify where to obtain detailed information regarding the topics discussed (and not discussed) in this presentation.

Speaker Introduction/Disclosures

- ★ Katherine is the owner of Afferent Connections, an SLP private practice and consulting business that offers resources and personalized Medicare billing assistance to other private practitioners. You may book a paid consultation with her for assistance with Medicare credentialing and/or claims, but you are under no obligation to do so and are encouraged to do your own research.

- ★ Katherine has no further financial or nonfinancial relationships to disclose.

Intro/My Story

What Is Medicare?

- ★ WHO: adults 65 and over who have certain number of work credits OR people with disabilities OR ESRD
- ★ WHEN: Started in 1965
- ★ WHAT: federal health insurance
  - Part A: Inpatient hospital, SNF, hospice care, home health after an inpatient admission
  - Part B: Outpatient doctors' services, **outpatient rehabilitation,** medical supplies, preventative care, other home health
  - Part C: Medicare Advantage or replacement plans
  - Part D: Prescription drug
- ★ HOW: For outpatient, after deductible/coinsurance, Part B pays for 80% (secondary/supplementary "Medigap" insurance, or patient, covers remaining 20%)
- ★ **WHY is it so scary?????**

Mandatory Claims Submission Rule

- ★ SLPs (and PTs/OTs) may NOT “opt out” of Medicare
- ★ For any skilled, medically necessary service we provide to a Medicare beneficiary (very few exceptions), this means we CANNOT:
  - Accept cash or private pay
  - Treat for free
  - Accept payment from patient and file an out-of-network claim
- ★ You MUST be credentialed with Medicare!

Before you say “forget it”...

- ★ You already know more than you think you do
- ★ Relatively straightforward (compared to commercial insurance)
- ★ Can be more lucrative than working for someone else
- ★ A growing number of people will need your services!

To bill Medicare, you need:

- ★ State license
- ★ Meet requirements for ASHA CCC
- ★ Business license (depending on your county and situation)
- ★ National Provider Identifier (NPI)
  - https://nppes.cms.hhs.gov/#/
- ★ Provider Transaction Access Number (PTAN)
  - Issued by your Medicare Administrative Contractor (MAC)
  - **What is the name of our MAC in Georgia?**

PALMETTO GBA®

A CELERIAN GROUP COMPANY

Jurisdiction J Part B (Alabama, Georgia, and Tennessee)

Applying for a PTAN

- ★ Apply online with the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)
  - https://pecos.cms.hhs.gov/pecos/login.do#headingLv1
- ★ Information/items needed include:
  - Voided check for direct deposit (personal or business account)
  - Tax ID number (SSN or EIN)
  - Form CMS-460 (more about this later)
- ★ Consultants can handle this for you
- ★ **YOU CAN BACKDATE (about 30 days)**
- ★ Processing times vary (usually at least 3-4 weeks)

Let's look at an application that was approved...mine!

Form CMS-460

INSTRUCTIONS FOR THE MEDICARE PARTICIPATING PHYSICIAN AND SUPPLIER AGREEMENT (CMS-460)

To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients.

WHY PARTICIPATE?

If you bill for physicians' professional services, services and supplies provided incident to physicians' professional services, outpatient physical and occupational therapy services, diagnostic tests, or radiology services, your Medicare fee schedule amounts are 5 percent higher if you participate. Also, providers receive direct and timely reimbursement from Medicare.

Regardless of the Medicare Part B services for which you are billing, participants have "one stop" billing for beneficiaries who have Medigap coverage not connected with their employment and who assign both their Medicare and Medigap payments to participants. After we have made payment, Medicare will send the claim on to the Medigap insurer for payment of all coinsurance and deductible amounts due under the Medigap policy. The Medigap insurer must pay the participant directly.

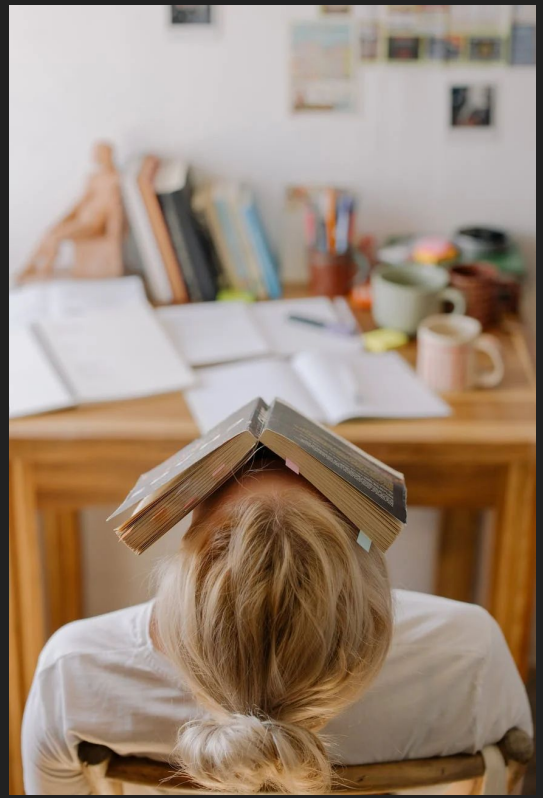
Currently, the large majority of physicians, practitioners and suppliers are billing under Medicare participation agreements.

Form CMS-460: Translation

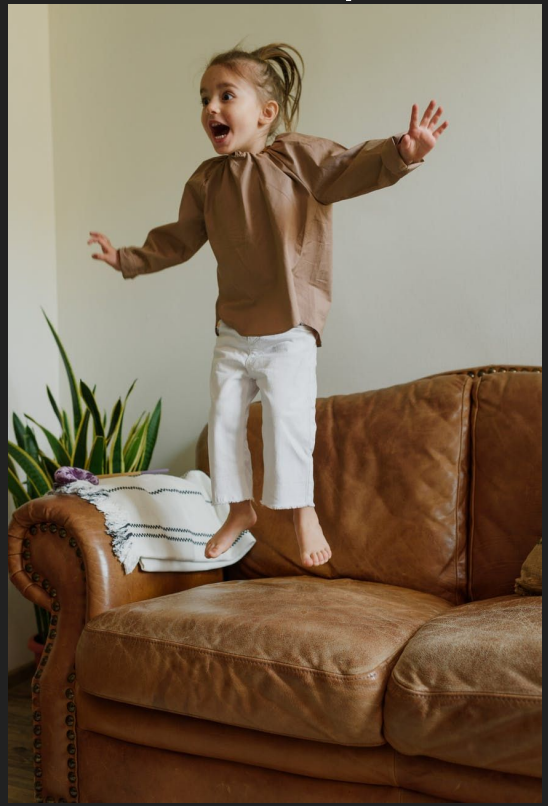
Participating Provider	Non-Participating Provider
★ Form CMS-460 needed ★ “Par” ★ You agree to accept the rate designated by Medicare, for ALL Medicare Part B patients ★ Rate will be 5% higher than “non-par” rate ★ You will collect nothing from the patient or secondary insurance; all done for you ★ Direct deposit from Medicare, no billing the patient (except any deductible and/or coinsurance)	★ NO Form CMS-460 ★ “Non-par” ★ You can choose whether or not to accept Medicare’s rate on a case-by-case basis ★ If you accept, this rate will be 5% lower than “par” rate ★ If you DON’T accept assignment, can collect additional payment from the patient (limiting charge) - totaling up to 115% of “non-par” rate and up to 109.25% of “par” rate ★ Direct deposit only if you accept assignment; you have to collect the money yourself, and patient is reimbursed the “non-par” amount, if you don’t accept assignment

Both
★ You have to be credentialed with Medicare! ★ You have to file a claim with Medicare!

Let that digest for about 5 minutes…



So your PTAN has been issued, and you're ready to see your first Medicare patient!



Before you evaluate/treat…

- ★ Patient or POA needs to sign these forms (in addition to any specific clinic/practice forms; can make your own or find/purchase “ready-made” and/or customizable forms online):
  - HIPAA/Privacy Policy
  - Medical Records Release forms
  - Consent to Bill Insurance

Before you evaluate/treat…

- ★ Ensure (via physician order*, correspondence, records request, etc.) that their diagnosis is covered by Medicare
  - 2022 ICD-10-CM Diagnosis Codes Related to Speech, Language, and Swallowing Disorders
  - *Georgia is a direct access state and you do not need a physician referral, just a signed POC
- ★ **Ensure they are not under a home health plan of care for ANY services**

Before you evaluate/treat, continued…

- ★ Get a copy of all their insurance cards!
- ★ Due diligence to ensure there is no payor primary to Medicare
  - 20.2.1 Admission Questions to Ask Medicare Beneficiaries
- ★ Call your MAC patient access center to verify benefits
  - 877–567–7271 for Palmetto GBA Juristiction J Part B
  - Palmetto GBA IVR Part B Call Flow Chart
  - ALWAYS write down the confirmation number, date, time, and agent's name

Time to start evaluation and/or treatment!

Medicare Part B covers visits…

- ★ In your clinic/office (properly registered when you applied for your PTAN)
- ★ In their homes - **verify that a home health agency is not providing any services before you begin!**
  - Private residence (permanent or temporary, e.g., house, apartment, hotel room)
  - ALF/ILF
- ★ SNF - ONLY if they have been there for >100 days/are a resident
- ★ ***You may NOT charge for mileage/travel.***

Telehealth?

Medicare Part B covers speech pathology via telehealth ***only during the public health emergency (PHE) related to the COVID-19 pandemic.***

- ★ This situation is rapidly evolving!
- ★ Providing Telehealth Services Under Medicare During the COVID-19 Pandemic
- ★ IF the PHE does expire AND Congress does not pass legislation for Medicare to continue to cover telehealth, ***then and only then,*** you may perform these services for private pay.
- ★ Call Congress to encourage them to make this permanent! Info will be on screen later in this presentation.

Documentation Quiz Time!

TRUE or FALSE?

- ★ You are required to use an electronic medical record (EMR).
- ★ A physician must sign your plan of care (POC) for Medicare to cover treatment.
- ★ A physician must sign your POC before you see your patient for any more sessions.
- ★ Your documentation has to be submitted to Medicare for your claims to be filed.
- ★ Your “day job” is making you do extra work when you document.

Documentation Quiz Time!

TRUE or FALSE?

- ★ You are required to use an electronic medical record (EMR).
  - **FALSE**, but MUST be legible and secured per HIPAA requirements.
  - Paper - under lock and key (cabinet, private office, safe, etc.)
  - Word processing software - saved on a private computer/laptop under lock and key
  - Electronic - encrypted (Simple Practice, WebPT, Google Workspace, etc.; ALWAYS WITH A SIGNED BAA)

Documentation Quiz Time!

TRUE or FALSE?

- ★ A physician must sign your plan of care (POC) for Medicare to cover treatment.
  - **TRUE.** Always, always, always.
  - However…
- ★ A physician must sign your POC before you see your patient for any more sessions.
  - **FALSE.** You may begin treatment immediately. You **must** make a good faith effort to get the POC signed within 30 days, but there is no need to wait to serve the patient.

Documentation Quiz Time!

TRUE or FALSE?

- ★ Your documentation has to be submitted to Medicare for your claims to be filed.
  - **FALSE.** You will not submit anything (except the form for your paper claim, if applicable. More on that later…).
  - However, pretend that Medicare *is* going to read everything.
  - If an audit reveals any errors, you may have to return any reimbursement!
- ★ Your hospital employer is making you do extra work when you document.
  - **PROBABLY TRUE.** Let's have a look…

Evaluation

- ★ Evaluation requirements, at minimum:
  - Diagnosis codes and statements (primary/medical diagnosis, when applicable, and treatment diagnosis).
  - Description of the specific complaints/deficits to be evaluated and treated
  - Test scores and/or outcome measures whenever possible
  - Statement of medical necessity
- ★ Serves two purposes:
  - Defense for billing the evaluation itself (what you did)
  - Setting up your defense for billing for future treatment (why is it needed)

Plans of Care (Initial and Subsequent)

- ★ POC requirements, at minimum (initial AND updated):
  - Diagnosis codes and statements (primary/medical diagnosis, when applicable, and treatment diagnosis)
  - Long-term treatment goals (SMART, of course)
  - Treatment plan
  - Therapy frequency and duration
  - Certification dates
  - ***Physician/NPP signature within 30 days*** (or at least your best effort) for *any* services to be covered
- ★ CAN be the same document as your evaluation, or not.
- ★ **The doctor does not need to read/sign your entire eval!**
- ★ **POC needs to be updated anytime any of the above information has changed!**

Documentation

- ★ Treatment notes (typically/traditionally):
  - Subjective - anything patient-reported or reported by anyone else (family, etc.)
    - PAIN and what you did in response
    - Anything that happened between last session and now
  - Objective - description of skilled treatment provided (measurements when possible)
    - % accuracy, dB measurements, etc.
    - Level of assistance
    - Why did the patient need you? What is skilled about it?
  - Assessment - “so what?”
    - Any conclusions drawn from information in the S or O sections
    - Response to therapy
    - Progress towards goals
    - Why is therapy still medically necessary?
  - Plan
    - Usually “continue POC”
    - If anything major changes, need to update POC
  - Treatment date/time
  - Signature of performing clinician

Documentation

★ Treatment notes (actually required):

- **Objective - description of skilled treatment provided (measurements when possible)**
  - **% accuracy, dB measurements, etc.**
  - **Level of assistance**
  - **Why did the patient need you? What is skilled about it?**

- **Treatment date/time**
- **Signature of performing clinician**

Progress Notes

- ★ Every 10 visits at minimum - the reporting period is measured from the end of the last reporting period till now (i.e., last progress note or re-eval/updated POC)
  - Can line up with an updated POC or discharge (if your certification period runs out before 10 visits)
  - Includes any updated outcome measures or other objective assessments (not required)
  - State which goals were met, which are progressing, and which are not progressing - with objective info such as therapy data whenever possible
- ★ Basically, this is to justify that therapy needs to continue exactly as you said in the most recent POC.
  - Are they making progress? If not, why?
  - Why do they still need therapy/to complete their POC?
- ★ Any changes to goals, diagnosis, treatment plan, frequency/duration, or extension of certification period requires an **updated POC with the NPP's signature**
- ★ **It needs to be sent to the NPP either way (only signed if updated POC)**

Discharges

- ★ Your final progress note - all the same requirements
- ★ Reporting period - since last progress note or updated POC
- ★ Other considerations:
  - Patient- or family-reported improvements (or lack thereof) in function outside of therapy sessions (e.g., participating in conversations more)
  - Mention of home maintenance plan (and describing what it is)
  - Indications for resuming therapy (e.g., decline in function, change in patient's personal goals, etc.)
- ★ If there is not a formal discharge visit (i.e., therapy was discontinued earlier than anticipated), be as thorough as you can based upon most recent visit(s)
- ★ **Also needs to go to the referring/signing NPP (no signature required)**

Documentation - final words

- ★ No one is grading you, and odds are, Medicare won't see it
- ★ HOWEVER, they very well could, and if you didn't document it, it didn't happen
- ★ Electronic signatures are okay - see Signature Requirements Acceptable and Unacceptable Examples for details
- ★ Time is money!
- ★ Overview of Documentation for Medicare Outpatient Therapy Services

Let’s take another brain break…

Claims

Claims Overview

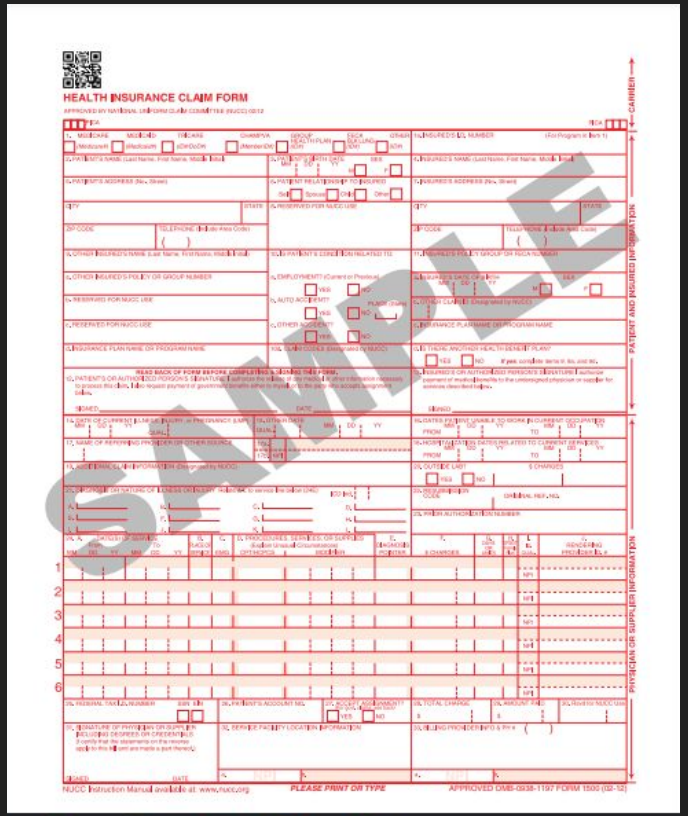
You can file Medicare Part B claims…

- ★ Via a third party/outsourced/hire an employee or contractor ($)
- ★ Yourself
  - ○ Electronically
    - ■ Commercial EMR/clearinghouse; e.g., Simple Practice, OfficeAlly, etc. ($)
    - ■ Jurisdiction J Part B - eServices Portal - FREE
  - ○ On paper - form CMS 1500 - FREE*
    - ■ *form costs money, filing is free
    - ■ Jurisdiction J Part B - CMS Claim Filing Instructions
- ★ **No matter who does your billing, at minimum, your first claim must be on paper!** You can continue to submit paper claims as long as you are only submitting </=10 per month
  - ○ However, I can **absolutely** guarantee you won't want to

Paper Claims

Form CMS 1500

- ★ You **must** use an original
- ★ Can fill it out by hand in pen, or type/print



Closer Look at CMS 1500

Let's take a brief look...

Closer Look at CMS 1500

- ★ How to EASILY Fill Out the CMS 1500 Form for Physical Therapy & Occupational Therapy #MCRBilling - more specific to rehab, but there are a few omissions/inaccuracies
- ★ Interactive CMS-1500 - look at this next to fine-tune
- ★ Random tips coming from me:
  - Unless the form itself says to leave an item blank, write “none,” “same,” or fill it out again (e.g., patient’s name/address/DOB).
  - DON’T FORGET THE TINY BOXES
  - If (when) your first one gets sent back or rejected, take a deep breath!
  - Just get through this first one and it will be smooth(er) sailing

Mail Paper Claims to:

Palmetto GBA
P.O. Box 100306
Columbia, SC 29202-3306

- ★ They may mail the claim back with corrections needing to be made
- ★ The claim may be rejected (but you can still resubmit with appropriate changes)
- ★ When claim is approved, you will still receive correspondence (EOB) but it will be direct deposit.
- ★ Call MAC after 2 weeks if you have not heard anything.

Palmetto GBA eServices

To apply, you need:

- ★ Submitter ID
- ★ Signed electronic data interchange (EDI) Enrollment Agreement on file
- ★ PTAN, NPI, tax ID, amount of last Medicare payment received
- ★ Jurisdiction J Part B - eServices Portal

An EDI will be issued. You will also need to link eServices to any clearinghouse (OfficeAlly, etc.) that you choose to use.

Odds and ends time!

Billing/Coding

Medicare CPT Coding Rules for Speech-Language Pathology Services

National 2022 Fee Schedule (versus 2021)

Place of Service Code Set | CMS

CMS Info About Modifiers

Let’s Make Some Changes!

Contact your members of Congress to urge them to pass legislation against ongoing Medicare cuts, as well as to keep telehealth covered

Resources for Further Medicare Assistance

- ★ Learn Medicare Billing for Outpatient PT, OT, SLP - Anthony Maritato (PT); “a la carte” consulting/webinars, has free YouTube videos
- ★ Confident Clinician - Collective run by SLPs; “a la carte” consulting and webinars
- ★ Gawenda Seminars - Rick Gawenda (PT); memberships
- ★ Afferent Connections - Katherine Stewart (SLP); my private practice and consulting business specific to SLP
- ★ Medicare Billing for (Mostly) Cash Based PT, OT, SLP Providers Group - Free Facebook group run by Anthony, Rick, and others

Questions?

katherine.stewart@afferentspeech.com