Audit Protection in 7 Steps
With Mario Fucinari DC, CCSP, CPCO, MCS-P, MCS-I
Presented by Foot Levelers

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About Dr. Mario Fucinari, DC, CCSP, CPCO, MCS-P, MCS-I

- Graduate of Palmer College of Chiropractic - 1986
- Currently in Full Time Practice in Decatur, Illinois
- Certified Chiropractic Sports Physician (CCSP) – Logan College of Chiropractic
- Certified Insurance Consultant - Logan College of Chiropractic
- Certified Medical Compliance Specialist Physician – Medical Compliance Training 2007
- Certified Professional Compliance Officer – CPCO (AAPC)
- Post-graduate Faculty of Palmer College of Chiropractic, NYCC, D'Youville College, Life West and Western States Chiropractic College
- National Speaker's Bureau for NCMIC and Foot Levelers and many state associations
- Past President of Illinois Chiropractic Society (ICS)
- Chairman, ICS Medicare Committee
- Member Medicare Carrier Advisory Committee
- ICS Chiropractor of the Year 2012
- Member of ACA and ICS

New information posted regularly at www.facebook.com/askmario and "Like" us

Medical Compliance Certification Class Info at www.Askmario.com

Chiropractic Under Scrutiny

CMS Should use Targeted Tactics to Curb Questionable and Inappropriate Payments for Chiropractic Services
http://oig.hhs.gov/oei/reports/oei-01-14-00200.asp

HUNDREDS OF MILLIONS IN MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES DID NOT COMPLY WITH MEDICARE REQUIREMENTS
https://oig.hhs.gov/oas/reports/region9/91402033.pdf

Strategic Health Solution

- Strategic Health Solutions has been contracted to perform and provide medical review functions of Medicare and Medicaid programs.
- Strategic Health is currently performing medical review of records through the project Y4P0434 for Chiropractic Services.
- Documentation will be reviewed for compliance on such issues as medical necessity, maintenance care and signature requirements.
- CMS will direct claims adjustments and recoupment efforts.

Look up your profile at :

http://graphics.wsj.com/medicare-billing-2015/

Compliance and Ethics

In 1991, the United States Sentencing Commission Federal Sentencing Guidelines were published. These guidelines were used by the United States government for the sentencing of organizations.

A mitigating factor in this determination has been the existence of an *effective* compliance program as defined in the Sentencing Guidelines. The health care industry has used the Sentencing Guidelines as a framework reference for establishing a compliance program and compliance guidance. Every clinic should develop and implement a Compliance Program. This is separate from HIPAA. It is required that all providers and personnel adhere to all components of the Program as it applies to their duties and responsibilities. The Compliance Program consists of seven foundational elements.

Seven Elements of Our Compliance Program

1. Designate a compliance officer;
2. Conduct comprehensive training and education;
3. Implement written policies and procedures;
4. Conduct auditing and internal monitoring;
5. Develop accessible lines of communication;
6. Enforcing standards through well publicized disciplinary guidelines; and
7. Responding promptly to detected offenses and undertaking corrective actions.

If you will, an eighth element has been added to make sure all employees and if applicable, members of the Board of Directors have been checked on the Exclusion Database List of the Office of Inspector General. https://exclusions.oig.hhs.gov/ Print and put in Compliance Manual.

- The government believes that a compliance plan will prevent violations and offer to reduce the potential for liability should violations still occur.
- Prevents violations, but should they occur, it would be abuse
- Lesser penalties are built into the law if they have a compliance plan
- The compliance plan acts as a mechanism as a training tool.
- Promote a culture of ethical behavior
- Fulfills our legal duty to filing truthful claims
- Good faith effort to compliance with the law
- Cost-effective
- Peace of mind to management
- Positive impact in the office, corporation and public image
- Simply good business practice

The Compliance Plan:

- To assure compliance with and conformity to all applicable federal and state laws and regulations governing the organization.
- A "Living Document"
- Must be an "effective" program
- A commitment
- Not a "one size fits all" program
- Must be reviewed at least annually

The goal of every office should be to adhere to all applicable state and federal regulations, while providing quality, comprehensive health care.

Compliance and Medicare:

Patient Protection and Affordable Care Act (Public Law 111-148)
Federal Register /Vol. 75, No. 184 /Thursday, September 23, 2010

- Must adopt a compliance plan as a condition of enrollment
- Patient care is first priority
- Speed an optimize proper payment of claims
- Minimize billing mistakes
- Help protect patient privacy
- Reduce the chance of an audit
- Avoid conflicts of interest
- Avoid anti-kickback and self-referral

Culpability score mitigation factors:

- Upper level employee "participated in, condoned, or was willfully ignorant of the offense"
- If the organization reported the offense promptly
- If the organization cooperated with the government investigators
- If the organization accepted responsibility for the violation

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Step One: The OIG Compliance Officer

Source Possibilities

- Compliance Officer
- Compliance Professional
- Compliance Committee
- Compliance Consultant

"To carry out such operational responsibility, such individuals shall be given adequate resources, appropriate authority, and direct access to the governing authority or an appropriate subgroup of the governing authority."

- *Federal Sentencing Guidelines*

- Oversee and monitor implementation of a compliance program
- Establish methods of audits to improve practice efficiency and quality of service
- Evaluate and revise compliance program
- Develop, coordinate and participate in training
- Ensure individuals are not on Exclusion List
- Investigate allegations of wrongdoing
- Monitor corrective actions

- Most important is access to others with qualifications
- No need to be a Jack-of-all-trades
- Do you need to be liked?

Step Two: Compliance Training and Education

- First line of defense for an organization
- Train new employees immediately and update as policies and procedures warrant
- Minimum of one to three hours annually for basic training
- Voluntary vs. Mandatory
- Attestation

Education Considerations:

- Identify the individual(s) for training
- Identify the type of training
- Determine the frequency of the training

Sample Educational Topics:

- Medicare
- HIPAA
- Security
- Stark
- Red Flags
- False Claims

- Code of Conduct
- Red Flags
- EMTALA

Areas to consider

- Record retention
- Self-disclosure
- Exclusion sanction checks
- Billing policies
- Unbundling
- Credit balance
- No charge visits
- Delegation of duties
- Documentation requirements.

Step Three: Policies and Procedures

Policies
"The set of basic principles and associated guidelines, formulated and enforced by the governing body of an organization, to direct and limit its actions in pursuit of long-term goals." *Business Dictionary, Businessdictionary.com

Procedures
"A fixed step-by-step sequence of activities or course of action…that must be followed in the same order to correctly perform a task."
*Business Dictionary, Businessdictionary.com

What is worse than not having a policy?

Policy and procedure statements should be placed in the Compliance Plan binder along with any forms and treatment guidelines.

Step Four: Auditing and Monitoring

1. Auditing
    1. Implement risk evaluation and auditing techniques
    2. Best if done by an outside entity so as not to be biased
    3. Must be independent and objective
2. Monitoring
    1. Based on assessment of risk
    2. Used as a management tool
    3. Day-to-day activities within the office
    4. Scalable to the risks and resources

Types of Audits:

- Concurrent audit - best
- Retrospective audit

  Baseline Audit
  - Risk assessment items
  - Interview employees
  - OIG Work Plan
  - Audit alerts
  - Benchmark for future audits
  - At least annually

  Snapshot audit

Risk assessment

- Follow the claim from the initial documentation to the claim submission
- Were the codes billed and reimbursed accurately ordered?
- What was the place of service?
- Were the services performed?
- Were the services reasonable and necessary for the treatment of the patient? (Medically necessary)
- Focus on highest-revenue and highest-volume services

If an overpayment or billing error is identified, a provider has 60 days to repay the amount.
Patient Affordable Care Act
Section 6402(d)(2)(A)(iii)

If repayment is not made, penalties can be up to three times the amount at issue plus and additional $11,000 per claim
Patient Affordable Care Act

Sample Questions to Evaluate Compliance

Medical Necessity/Documentation

- Does the practice have adequate processes to review medical records for medical necessity and proper documentation?
- Does the practice ensure physician orders are completed correctly? (signed and dated?)

Denials

- Does the practice maintain current standards and procedures for handling denials?
- Does the practice maintain a log of current and past denials?
- Does the practice have a process to analyze denials to determine common patterns?

Credit Balances/Refunds

- Does the practice maintain current standards and procedures for handling credit balances?
- Does the practice assign individuals the responsibility of tracking and handling credit balances?
- Does the practice maintain a refund and/or disclosure procedure to correct overpayments to ensure identified overpayments are repaid within 60 days?

Exclusion List

What to do if an employee is on the list

- Temporarily remove them from providing services involving government programs
- Discuss with legal counsel
- Refund money to government if appropriate
- Review exclusion documents. What did they do?
- Return employee after exclusion is expired

Step Five: Lines of Communication

Qui Tam/Whistleblower

Must have a whistleblower policy

- Non-Retaliation policy
- Who do they respond to?
    - Management;
    - Compliance office; or
    - Compliance hotline

Whistleblower Policy (WP)

- Positive employee relations and morale are achieved best when they are in a working atmosphere of ongoing open communication between management and supervisors and staff.
- The employee's views are important
- The WP will encourage employees to come forward and communicate problems, concerns and opinions without fear of retaliation or retribution.
- When reporting to the OIG, the person can report anonymously
  www.oig.hhs.gov
  1-800-HHS-TIPS

Policy

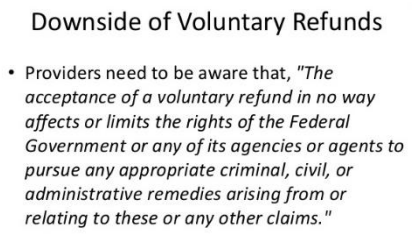
- Just saying that one has an open-door policy is not enough
- Employees must be given a range of reporting options
    - Cell phone has caller id
    - E-mail has caller id
    - Answering machine
    - Forms
    - Compliance officer
    - OIG hotline

Code of Conduct

- "First among equals"
- Fundamental statement of the organization's values and standards
- The most public of the organization's compliance statements
- Demonstrates the organization's ethical attitude
- Should be written plainly (8th grade level)
- Tailored to the business culture or identity
- Foreign language, Braille, sign language
- Not in the Seven Elements?

Step Six and Seven: Enforcing standards through well publicized disciplinary guidelines; and Responding promptly to detected offenses and undertaking corrective actions.

Voluntary Refund?



Areas to Consider in Your Compliance Risk Assessment

The Consultation

The Rues of Documentation

- If it is not written, it never happened
- Write legibly!
- Be concise
- Be original
- Use only standard abbreviations
- Patient's name on all notes
- Is the patient record complete?

Box 14:

Medicare Initial Encounter Report

Symptoms causing patient to seek treatment
Family History
Past Health history
Mechanism of Trauma
Quality and character of symptoms/problem
Onset, duration, intensity, frequency, location and radiation
Provoking and Palliative Factors
Prior interventions, treatments, medications, secondary complaints

Treatment Plan

- Frequency and duration
- Treatment Goals
- Care Plan

Chief Complaint – a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient's own words.

Family History – _____ Factors

specific health related events in the patient's family. Includes information about the health status or cause of death of parents, siblings, and children and the following diseases:

Orthopedic (arthritis, scoliosis)
neurologic
pathology (heart disease, cancer, diabetes)

The Big Five

Past Health History _____ Factors

Social History _____ Factors

Marital status

History of Present Illness (HPI)

L, M, N, O, P, Q, R, S, T

Medicare Subsequent (Daily) Visits SOAP
Medicare SOAP

I. History

Review of chief complaints (is this in relationship to the initial visit or treatment for the exacerbation)
Changes since last visit
Progress towards goals
System review if relevant

Railroad Medicare: Always address the following: _____

II. Physical Exam

Exam of area of the spine involved in Dx..
Assessment of change in patient condition since last visit
Evaluation of treatment effectiveness
Subsequent Visits

III. Evaluation of treatment effectiveness

In regards to the recommended level of care, duration, frequency and goals that were developed at the initial visit or at the time of exacerbation.

IV. Documentation of treatment given on day of visit.

- You must document the actual segments that you adjusted.
- Document the response to the adjustment. "patient tolerated treatment without incident"

Evidence Based Outcomes Assessment Tools (OATs)
Measures <u>Functional Impairment</u>

Why Outcomes Assessment?

- An objective measure of the patient's status
- Provides objective documentation regarding the patient's condition.
- Helps the doctor, patient and insurer to make *informed* decisions
- A deterrent to malpractice
- Backed up by refereed journals (JMPT, Spine)

Outcomes Assessment Tools

- Have patient complete on initial exam, on re-exam or as clinically indicated and at any exacerbations.
- These tests *quantify* the amount of patient deconditioning present.
- A measure of the patient's **<u>functional</u>** impairment of activities of daily living.

Outcome Assessment Tests

- Visual Analog Scale
- Pain Drawings
- Revised Oswestry Low Back Pain Disability Questionnaire
- Roland-Morris Disability
- Neck Pain Disability Index Questionnaire
- Headache Disability Index
- Bournemouth Questionnaire – Cervical and Lumbar. "Lifestyle illnesses"
- Zung Psychological Assessment Questionnaire

Neck Pain Disability Index Score

0-8% = None
10-28% = Mild
30-48% = Moderate
50-68% = Severe
>70% = Crippled

Revised Oswestry Score:

0-5% = None
6-20% = Mild
20-40% = Moderate
40-60% = Severe
60-80% = Crippled
80%+ Bed Bound

*If you compare the original score to the score at re-examination, there must be a minimum of a 30% decrease in score on re-evaluation to be clinically significant.

Re-Examination

- Formal re-examination should be done "to determine progress and need for further care"
- Should be done every 10-15 visits or every 30-45 days. **RECOMMENDED EVERY 30 DAYS**
- Recheck all positive findings and significant negative findings.

Medicare Guidelines for Re-evaluations

- Demonstrate the patients' progress in objective, rather than conclusory terms
- The evaluation elements, noted in the initial evaluation need not be documented at each treatment; however, they must be present often enough to show measurable progress, or failure to progress

A re-examination should include

- A brief consultation about current condition
- Repeat of significant orthopedic and neurologic tests
- Visual Analog Scale or Borg Scale
- Outcome measures test repeated

After the re-examination, update record with an interim note or report. This will document and explain the clinical significance of why you did the exam (rationale) and the results of the exam. This then leads to your treatment plan and treatment goals.

- Any change in diagnosis
- Treatment frequency/schedule
- Treatment goals
- Restrictions
- Referrals or further tests
- Exercise/rehabilitation

Assessment – What do you think? Used in Medical Necessity

- Provider records their professional opinions and judgments as to the patient's diagnosis, their progress and/or their functional limitations.
- You interpret the data presented in the objective portion of the note.
- You may also point out inconsistencies, justify your goals, discuss emotional status or indicate progress in therapy.
- You may also present reasons why certain information was not obtained or deferred.

What is Medical Necessity?
How is the patient improved?
Why does the patient still need care?

Treatment Plan

Treatment Plan:

1. Treatment Frequency
2. Treatment Goals
    a) Short-term Goals

    To decrease pain, spasms and edema
    Resolution of any radicular pain in the lower extremity
    Low back pain consistently less than or equal to 6/10 with all activities
    Resting low back pain with less than or equal to 2/10
    Independent with basic self-care ADL without increased low back pain

    b) Long-term Goals

    Address their ADL
    Low back pain at worst less than or equal to 4/10 with all activities
    Patient will ambulate 15 minutes at 2.0 miles per hour without increased low back pain
    Bilateral hip flexion, multifidus and gluteal strength to 4+ to 5/5
    Independent self-management
    To prepare the patient for a home-based exercise program

3. Care Plan

Example:
In the acute stage: manipulation, EMS (unattended), ice, pulsed ultrasound and patient education as indicated

In the sub-acute stage: manipulation per palpation, skilled therapeutic rehabilitation exercise to improve functional capacity, strength and endurance and to decrease pain with ADL and patient education as indicated

Specific Treatment Goals

What are you trying to accomplish?

Objective measures to evaluate treatment effectiveness

How do you know when the treatment has been accomplished?

Recommended Level of Care

Duration and frequency of visits to accomplish the above goals

Audit of the Subluxation:

Under Part B Medicare, a chiropractor is "approved for treatment by means of manual manipulation of the spine to correct a subluxation.

Medicare P.A.R.T.

P.A.R.T.

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned under the above physical examination list are required, one of which must be asymmetry/misalignment or range of motion abnormality.

P.A.R.T.
(2 of the 4 Required)

1. Pain/Tenderness - location, quality, intensity
   Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation, provocation, etc. Furthermore, pain intensity may be assessed using one or more of the following: visual analog scales, algometers, pain questionnaires, etc.

2. Asymmetry/misalignment - sectional or segmental level
   Asymmetry/misalignment - Asymmetry/misalignment may be identified on a sectional or segmental level through one or more of the following: observation (posture and gait analysis), static palpation for misalignment of vertebral segments, diagnostic imaging, etc.
3. Range of Motion Abnormality
   Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and Range of motion abnormality - Range of motion abnormalities may be identified through one or more of the following: motion, palpation, observation, stress diagnostic imaging, range of motion measurements, etc.

4. Tissue, tone changes in skin, fascia, muscle, ligament
   Tissue, tone changes using descriptions pertaining to the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament. Tissue/Tone texture

may be identified through one or more of the following procedures: observation, palpation, use of instruments, tests for length and strength etc.

Provider Signature Requirements

For medical review purposes, Medicare requires that the author authenticate services provided/ordered. Medicare denies many claims due to the lack of an appropriate signature. Here are some things to keep in mind on signature requirements:

1. The signature must be that of the provider of service. This means the person providing the service whether that is the physician or a non-physician practitioner (NPP). No one else can sign for the physician; this includes another physician in a group, the senior nurse, etc.
2. The signature must be hand-written or electronic. Medicare does not accept stamped signatures.
3. The Centers for Medicare & Medicaid Services (CMS) 1995 and 1997 Documentation Guidelines (DG) for Evaluation and Management (E/M) services require that the provider's signature be legible. If your signature is not legible, please provide a signature log or authentication statement verifying the information.
4. The signature of the transcriptionist is not the same as the physician signature. While your office may need or require this information, Medicare does not.
5. If you are using electronic medical records, please verify your system and software products protect against modification. Providers using electronic systems should recognize the potential for misuse or abuse with alternate signature methods.
6. If you are splitting or sharing services between yourself and a NPP, then both parties must sign their portion of the service. The NPP cannot sign for the physician.
7. Physician offices should have a protocol in place to have physicians sign their records within a reasonable time, generally 48 to 72 hours after the encounter, but certainly prior to submitting the claim to Medicare.
8. **You cannot add a signature to a record later (this does not include the brief time to transcribe the record), instead use an attestation statement.**

No signature on progress/treatment note submitted – attestation sample

"I, (name of doctor)_____, hereby attest that the medical records entry for the date of service _____ , accurately reflects signature/notations that I made in my capacity as a D.C. when I treated/diagnosed _____."

I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

Signature: X _____ Date Form Completed X _____

59 Modifier Updates

- Modifier 59 - Distinct Procedural Service
- Modifier XE - Separate Encounter: A service that is distinct because it occurred during a separate encounter
- Modifier XS - Separate Structure: A service that is distinct because it was performed on a separate organ/structure
- Modifier XP- Separate Practitioner: A service that is distinct because it was performed by a different practitioner
- Modifier XU - Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service

a. Ensure that you have clinical circumstances to justify the modifiers and please do not append to HCPCS and CPT codes to simply bypass the NCCI edits.
b. Medicare considers two physicians in the same group with the same specialty performing services on the same day as the same physician.

ICD-10 Coding and Documentation

ICD-10 Freeze ended October 1, 2016. <u>Convert to Phase 2</u>

ICD-10 Phase 2 went into effect October 1, 2016.

- 1943 new ICD-10 codes added
- 422 revisions
- 305 deleted codes

ICD-10-CM

- The increased specificity of the ICD-10 codes requires more detailed clinical documentation in order to code some diagnoses to the **highest level of specificity**
- There are "unspecified" codes in ICD-10-CM for those instances when the health record documentation is not available to support more specific codes
- The benefits of ICD-10 cannot be realized if non-specific codes are used rather than taking advantage of the specificity ICD-10 offers

Sequencing of ICD-10 Codes

- Numbers are reported on the insurance claim form because you are communicating to a computer.
- Be sure to use the correct numbers, to the highest degree of specificity. This must be supported by the chart documentation.
- The diagnosis you provide directly relates to the level of care permitted by the third-party payers.

Sequencing in ICD-10

Optimal sequencing of the codes:

- Neurological diagnosis
    -
    -
    -
- Structural descriptor diagnosis
    -
    -
    -
- Functional diagnosis
    -
    -
    -
- Soft tissue
-
-
- Extremity

Medicare Medical Necessity

1. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3)

2. You must have a reasonable expectation of recovery or improvement of **function.**

3. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam. A diagnosis of pain is not sufficient for medical necessity

- **Acute subluxation** - Acute subluxation - A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.

- **Chronic subluxation** - A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3)

An **acute exacerbation** is a temporary but marked deterioration of the patient's condition that is causing significant interference with activities of daily living due to an acute flare-up of the previously treated condition. The patient's clinical record must specify the date of occurrence, nature of the onset, or other pertinent factors that would support the medical necessity of treatment. As with an acute injury, treatment should result in improvement or arrest of the deterioration within a reasonable period of time.

Maintenance Therapy

- Once MMI has been reached, Medicare will NOT pay for maintenance or supportive care.

___ Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or ____ maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3A)

1.

2.

Episode of Care

Advance Beneficiary Notice of Noncoverage (ABN)

1. One ABN for maintenance manipulation and one for non-covered services ("voluntary")
2. Good for up to one year
3. Signed copy to patient
4. Update as needed
5. *Personally* signed and dated by the patient

Red Flags of the ABN:
Name:
Identification Number:
Options:
Signature and Date:

Sources:
CMS ICD-10

www.Askmario.com

www.facebook.com/askmario - for Free

Footlevelers.com Free Webinars

- ***ICD-10 Coding of the Top 100 Conditions for the Chiropractic Office*** by Dr. Mario Fucinari www.Askmario.com
- The ***Compliance Program Manual for the Chiropractic Office*** gives you the tools you need to plan and execute a customized compliance program that meets federal standards. The Manual takes you through the procedures necessary to address all of the standards outlined in the Federal Sentencing Guidelines for an effective compliance plan. The seven steps of the compliance plan and the Exclusion Elements are thoroughly discussed with step-by-step procedures to meet all the guidelines. Available at www.Askmario.com
- **Order Your Chart Audit www.Askmario.com**

New information posted regularly at
www.facebook.com/askmario "Like" us
Put us in your notifications

If you have questions…
www.AskMario.com
E-mail: Doc@AskMario.com

Thank You!!

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1														NPI	
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

OMB APPROVAL PENDING

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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