MediScare 2020
Be Prepared, Not Scared!

8 Medicare Hours CE or (1 hour Risk and 3 hours Ethics, Recordkeeping, Documentation and Coding)

Risk. Is that what comes to your mind when you hear the words: Medicare, documentation or compliance? If you feel afraid, you are not alone. Over the last seven years, chiropractors have refunded MILLIONS to Medicare. All of these doctors made the exact same mistake. Attend this class and you will find out what that mistake is and how to avoid it. Be prepared, not Scared!

PART ONE lays the foundation with a brief look at important laws to help you navigate the maze of confusion and minimize risk. then on to why the Initial Visit documentation is so important. Miss this and it could cost you big! We conclude with revealing the diagnosis codes with the longest treatment times.

PART TWO takes you into the five easy steps to documenting a daily visit, treatment plan compliance for even the most stubborn patients and protecting yourself and income with the ABN. This session finishes with a clear description of maintenance care and how to collect for it. Participants that attend both sessions will leave with the "care" back in Medicare!

Course Curriculum

PART ONE: 4 hours Medicare or (1 hour Risk and 3 hours Ethics, Recordkeeping, Documentation and Coding)

Eliminate the Risk and Learn, What Do You Do? - 2 hours

- What Is Medicare?

- How to Participate in Medicare
- Par Vs. Non-Par
- The Difference Between Medicare Part B and C?
- What Does Medicare Cover
- Non-Covered Services
- Giving Gifts and Collecting Referral Fees
- MACRA –New Law, Don't be a Target!
- Seven Good Reasons to Be a Medicare Provider

INITIAL VISITS: TEN VITAL POINTS - 2 hours

- Verifying Medicare as Primary Coverage
- Who Pays First? Medicare as Secondary Payer
- What Is the Date of Initial Treatment?
- Initial Visit; How is Medicare Different?
- It's All About Function: Functional Outcome Assessments
- Medical Necessity = Payment
- Silent Subluxations and the PART Exam
- Three "Patient Status", Medicare only pays for Two
- Diagnosis is Key to Treatment Plan Length
- CPT Coding the Initial Visit and Collecting your Fees

PART TWO – 4 hours Medicare (or Recordkeeping, Documentation, Coding)

SUBSEQUENT VISIT: MEDICARE FOLLOW-UP TREATMENT, WHAT DO YOU DO? - 2 hours

- Subjective: How to Review the History
  - What is your "Date of Initial Treatment"?
  - Chief complaint, VAS and Functional Rating Index
  - Note Changes Since Last Visit
  - System Review if Relevant
- Objective: How to do the Required Physical Examination
  - PART Exam
- Assessment:
  - Assess Changes Since Last Visit
  - Evaluate Treatment Effectiveness
  - Document the Treatment Given
- Plan:
  - Updating the Treatment Plan

- When Is It Time for A Re-Exam?
- When Is It Time to Release The Patient?

Treatment Plan Compliance, What Do You Do? - 2 hours

- Doctor Compliance with Treatment Plans
- How to handle the treat and release patient.
- How to handle the non-compliant patient.

- **How to Handle Maintenance**
  - Remember the ABN
  - The difference between Active and Maintenance Care
  - What does a maintenance note look like?
  - How to bill for maintenance
  - What to collect for Maintenance

Time Permitting

- Practical Documentation Examples
- Q & A Session

<u>The following Books, Guidelines, Manuals and sources will be used, studied or cited during course:</u>

- ✓ CPT Code Book, AMA
- ✓ 1997 Documentation Guidelines for Evaluation and Management Services
- ✓ The Chiropractic Services Manual – CMS
- ✓ Local Coverage Determinations
- ✓ The Commentary on Centers for Medicare and Medicaid Services (CMS) PART Clinical
- ✓ Documentation Guidelines – American Chiropractic Association (ACA)
- ✓ **MLN Matters® Number: SE1601**
- ✓ **MLN Matters® Number: SE1602**
- ✓ **MLN Matters® Number: SE1603 Revised**
- ✓ **MLN Matters® Number: SE1101 Revised**

<u>What Skills Participants Will Be Able to Implement Monday Morning:</u>

- ✓ Medicare's Definition of Subluxation
- ✓ How to Use the Medicare Diagnosis List for Compliant Documentation
- ✓ When to use the "AT" Modifier
- ✓ Exactly, what needs to be recorded on the "Initial" Visit
- ✓ Exactly, what to document on daily S.O.A.P. Notes or "subsequent" visits

- ✓ When to release a Patient to Maintenance Care and use the “GA” Modifier
- ✓ How to write a treatment plan with goals, duration and frequency of visits
- ✓ How to document the attainment of treatment goals, and what to do if the goals are not met
- ✓ Proper use of the ABN
- ✓ Proper coding and billing of services
- ✓ Avoiding “no-no’s”: illegal inducements and waiving of co-pays or deductibles