CHIROPRACTIC NEWS & VIEWS

Presented by:

Hawaii State Chiropractic Association, Inc.

Volume XII, December 2015

"MELE KALIKIMAKA ME KA HAU´OLI MAKAHIKI HOU"!

HI State Chiropractic Association
P.O. Box 22668
Honolulu, HI 96823-2668
Ph: (808) 926-8883 Fx: (808) 926-8884
www.HawaiiStateChiropracticAssociation.org

PLEASE JOIN US FRIDAY EVENING, 7:30PM, DEC. 10TH AT THE SAINT LOUIS ALUMNI CLUBHOUSE…MEETING OPEN TO ALL, MEMBERS & NON. *916 COOLIDGE ST., HONO., HI*

PRESIDENT'S MESSAGE

Joseph G Morelli Jr DC FICC, HSCA President & ACA Hawaii Delegate

Aloha All:

The holidays are here and it is the end of the year, and I am still doing paperwork from the early fall! It just seems that we can never catch up!

I hope that none of you has had too difficult of a time in the ICD-9 to ICD-10 transition.

I have heard from a few of our members that they have had some claim denials based on incorrect coding. I think that as time goes on, and one gets enough claims under one's belt, that it will get easier.

Remember, you have to be especially careful with Medicare, since it has a restricted list of specific codes that can be used to diagnose. We have posted these codes and the latest Medicare requirements for claims on the HSCA website.

On our homepage, click on the "Resources" tab, and then on the word "Medicare". This brings up the latest "LCD's". (Local Carrier Determinations). This is what CMS in Washington had approved for Noridian (our Medicare Contractor) to use regarding Chiropractic claims.

You can download this document as a PDF file. If you have any questions, please give me a call, and I will try to help you as best as I can.

As you may remember, every fall comes out with a new Medicare Fee Schedule linked to all the medical CPT Codes that it covers. The final ruling came out recently and there is only a slight change in the coding that we most directly use. Most of the fees show a slight increase, with a few slight decreases as an offset.

To add to the overall complexity of the fees, there are multiple fees for the same codes. This is because of the "negative adjustments" (fee reductions/penalties) if you do not participate in the PQRS program or utilize a certified EHR software program. In addition, of course, there is the "Par" vs. the "Non-Par" fees.

Whether you ever treat a Medicare patient or not, this still has significant pressure on your income if you treat auto accident or work injury patients. As you know, the State of Hawaii uses the latest Medicare Fee Schedule as the basis of its Workers Compensation Fee Schedule, which is also used in auto claims.

In the near future, we will send out a copy of the simplified Medicare Fee Schedule to all HSCA Members. Please make sure we have your most current email address and contact information, or you will not get one.

One other note regarding Medicare…CMS has recently sent out notice that the **2016 Medicare Deductible** has gone up from $147 to **$166.** This is the first increase in several years.

This means that beginning January 1st, 2016, all Medicare patients are responsible to pay out of pocket the first $166 they ring up charges regarding all Medicare "covered" services they receive regardless of provider.

Therefore, if you are the first medical practitioner that a Medicare subscriber sees in 2016, they must pay you up front any "Medicare Covered" charges until they have satisfied the deductible.

Please note that a patient may see several doctors, etc. so it is important to ask if they paid their deductible with other practitioners.

Noridian only knows the particulars of who paid what to whom when billings are sent in. (Has the deductible been met yet?)

My suggestion is always send in your Medicare claims as soon as you can to keep all the billings straight, and so you can collect the proper amount from your Medicare patients.

Remember, Medicare currently only covers the CMT services, so that is all that can apply towards the deductible.

All other services are considered "non-covered" and you can, at the time of service, collect for those services directly from the patient along with the 20% co-pay (for the covered CMT) if you are a participating provider.

Non-Par providers can only collect on "covered services" up to the "Limiting Charge". Non-covered services are collected as per usual.

New topic…..HMSA!

As you may recall, HMSA has been causing a fair amount of problems regarding how it adjudicates Chiropractic claims over the past year.

Due to "ObamaCare" we were finally being paid for all of our services from HMSA. So services performed in 2014 were being paid with little problem. Then, HMSA decided to develop a much more restrictive Chiropractic Services Policy, and limit the number of visits and services.

The HSCA jumped right in, and we began knocking on the doors at HMSA to see how to fix this.

Unfortunately, there was a large internal "shake-up" at HMSA, and some major management re-organization.

This really slowed down our efforts to right some of the wrongs we were enduring as a profession.

We put together committee to try to do what we could to educate and turn around HMSA.

At our last face-to-face meeting with HMSA, we finally got to speak to some of the major decision makers. We were able to revamp their very restrictive, non-clinically based policy to a much more familiar, current "standard of care", with a better clinical foundation.

This re-do of the HMSA Chiropractic Services Policy is currently going up the chain of command at HMSA, and so far we have seen very little resistance to it. Hopefully beginning January 1, we will have a new and improved policy in place.

To find out about these issues and more, please make it a point to come to our next General Membership Meeting, on Friday, December 11th at 7:30pm. The meeting will be held at the Saint Louis Alumni Clubhouse in the Kaimuki area of Honolulu. Refreshments are available for purchase, and you are welcome to bring a snack if you like.

At this meeting, we will do an update on relevant legislative activity thus far, in preparation for the opening of the 2016 Legislature.

Aloha,

Dr. JOE Morelli

THE ALOHA STATE FACES UNIQUE CHALLENGES IN THE HEALTH MARKET DUE TO INSIDE AND OUTSIDE FORCES.

Federal-state tension

Hawaii Health Information Corp. President and CEO Pete Sybinksy called the Affordable Care Act a "complex phenomenon."

"The initial indications are yes, it's doing the right things, it is bringing 9 million people into coverage nationally," he said. "It's a good piece of legislation for the Mainland, but for Hawaii there are some wrinkles. We feel that our health system can be impacted in a negative way."

Hawaii's unique Prepaid Health Care Act, enacted four decades ago, is largely to thank for making the state's uninsured rate one of the lowest in the nation. But the employer's contribution to health care plans has spiraled upward by 3,000 percent since 1974, due to the law's cost-share structure, escalating health care costs, and fees related to the Affordable Care Act.

Hawaii's law requires employers to offer workers health insurance if they work more than 20 hours per week. It was the first law of its kind in the nation to set a minimum standard for employee health benefits, according to the state.

A state task force is developing a waiver request that would protect the local law amid other Affordable Care Act plans to be offered under the federal platform.

Another challenge for Hawaii hospitals is the plunge in Medicare reimbursements.

During the 2015 federal fiscal year, Hawaii saw direct Medicare reimbursements decline by $18 million. Hawaii hospitals are currently reimbursed 86 cents for each dollar they spend on Medicare services, according to the Hawaii Health Information Corp.

Anticipated cuts could translate to $838 million in lost revenue over the next 15 years and an 11.2 percent reduction in total Medicare fee-for-service revenue over the next 10 years. In addition, Hawaii hospitals could be underpaid by $2.5 billion over the next decade if current patient volume and payment reimbursement rates continue.

This poses a particular challenge to community health centers. A majority of Waikiki Health's patients have Medicare, Medicaid or Med-QUEST insurance, or no insurance, and just 16 percent to 20 percent privately insured.

"It's interesting because for the providers at our health center you have to juggle private insurance to Medicare to Medicaid, and to be aware about things like using a certain pharmacy for certain meds," says Jeanelle Ahuna, physician assistant and associate clinical director at Waikiki Health. "[For example,] I can offer [the patient] coupon savings, or samples. It's kind of hard to juggle for all of the providers."

Art Gladstone, CEO of Straub Clinic & Hospital and Pali Momi Medical Center, says hospitals have gotten creative in dealing with declining reimbursement.

"We use systems to help identify the right ordering of tests and electronic health records to guide physicians to which lab studies and such should be deployed when diagnosing a patient," he said. "We manage the resources that go into care for patients pretty well in Hawaii and I think we're kind of used to the Medicare reimbursement [levels]."

Quality over quantity

One of the hallmarks of the Affordable Care Act is its effort to improve the quality of care through physician incentives. Reimbursement is now tied to patient outcomes through "pay for quality" measures.

Quality measures enforced by the Centers for Medicare and Medicaid encouraged such behavior before the federal law was enacted, says Gladstone.

"We did start to implement changes focused on improving the quality that we deliver to patients before the ACA came to be," he said. "The transition has been relatively smooth. For us, it's about engaging the front lines to make sure they understand what the goals are and what their role is in that."

While tracking and rewarding high-quality care is likely to benefit patients and the system as a whole, Dr. Anna Loengard, chief medical officer of The Queen's Health Systems' Queen's Clinically Integrated Physician Network, warns that an unintended consequence could be doctors "cherry-picking" their patients.

"If you essentially incentivize physicians to cherry-pick healthier patients … then people who are taking care of more challenging populations are going to earn less just by the nature of not being able to do as well on those quality metrics," Loengard explained. "The question then becomes, how do you account for that and give everyone incentives to collectively care for a population rather than sort of [picking] the ones who are going to be easier to demonstrate outcomes."

The shift in focus toward quality has led to new strategies. The Affordable Care Act allows room for flexibility as providers meet requirements to measure patient outcomes.

Some agencies have adopted Accountable Care Organizations, which stratify risk for doctors who take on more at-risk patients. Physicians who own their own practice may also enter an accountable care organization.

Hawaii Pacific Health's physician-led group, Hawaii Health Partners, launched almost two years ago and includes 700 physicians of all specialties. That gives the ACO a reach of about 100,000 patients, according to Dr. Gerard Livaudais, executive director of Hawaii Health Partners.

"ACOs were made possible by law in the Affordable Care Act to allow different business entities to come together under one new entity without fear of any repercussions or prohibitions that used to keep everyone in different camps," Livaudais said. "We set out to define quality for the people we serve."

Hawaii Health Partners plans to reward its physicians for their work in 2014 with a bonus that could reach about 10 percent of their income.

"Most of the drive behind this is the desire to reduce the cost trend," he said. "If you're doing it right it should result in lower costs."

On both a national and state scale, the patient is supposed to be taking center stage. And the best way to keep patients healthy is by preventing problems before they crop up.

"Everything that we're trying to do collectively in this community is really about putting the patient in the center, and figuring out how to get the patient the right care, at the right time, in the right place," Loengard said. "In general, I think that will end up being less costly to our system. It'll certainly end up being more customer-friendly for the person

experiencing care. Giving them preventive care, rather than ending up in the emergency room, is a win for everyone, really. It's not how our system's been designed [traditionally]."

Focusing on preventive care has been an integral part of the Hawaii Dental Service, says Mark Yamakawa, president and CEO. Patients regularly come in for checkups and teeth cleanings.

Prevention saves money in the long run, he said, noting poor oral health is directly correlated to other ailments such as diabetes and heart disease.

Like physicians, dentists are now thinking about how best to measure quality. It's only a matter of time before such measures are implemented and verified, he said.

"Employee groups are asking for value of plans," he said. "I think for us, it's actually beginning the dialogue within the dental profession. What is good quality? How do you reward it?"

Dentists are working to increase visibility in the community about the importance of preventive oral health care.

Technology Integration

Sharing data will be key in the coming years. That may be a tall order, given the mishmash of systems now in use. There are currently approximately 16 different electronic medical record systems in the state, according to Sybinsky.

It's one of the toughest issues doctors face today. Emergency rooms see crowds of patients every day without health records. It's even difficult to touch base with patients who made an emergency visit for a follow-up at times, says Ahuna.

Easy accessibility to patients' records means better treatment for patients. The Hawaii Health Information Exchange was established in 2006 to enhance care coordination in Hawaii. It launched its Health eNet Community Health Record, a source base of clinical information for all providers.

Through the Health eNet, doctors, hospitals and providers may connect their computer-based patient record systems to a secure, encrypted electronic statewide network.

Hospitals including Castle Medical Center, Hawaii Health Systems Corp., and The Queen's Health Systems have contributed to the record.

Loengard says Queen's is looking to get 400 physicians on a referral platform for the community health record by the end of November.

The integration will allow for greater doctor-patient awareness. Doctors will know which health plans cover which patients, something that is particularly useful in emergency settings.

It will just take time to get everyone on board, especially because electronic medical records currently come in all forms. Some are still based on technology from the 1980s.

Physician shortage

Hawaii is short of physicians in practically every category, according to our health care panelists. "Clearly, there are shortages in primary care, and from our network standpoint, we don't have enough oncologists and cardiologists — on the Neighbor Islands, there are some communities that don't have a cardiologist at all," Loengard said.

Yamakawa said that there are a significant number of dentists in Hawaii, especially in the urban core, but there's a real need for them in rural areas on Neighbor Islands.

While the shortage is clear, there are existing strategies to tackle the problem, according to Gladstone. The trick is helping physicians develop efficient practices and to collaborate.

"An example would be [using] a team of people to reach out to that patient to schedule appointments," he said. "We've been able to add patients into our primary care physician panels by creating those efficiencies."

Hawaii's highest earners are working in the medical field, according to a recent report by American City Business Journals, but when you consider the high cost of living, it is often challenging to attract physicians and professionals, experts say.

Dr. Timothy Duerler, a former University of Hawaii family medicine program resident, launched Mango Medical with his wife, a nurse practitioner, a few years ago.

Mango Medical was one of PBN's Fastest 50 companies of 2015, ranking No. 13 with 165 percent growth between 2012 and 2014. It has expanded from two to 12 primary care providers at six locations on the Big Island and Maui.

Duerler currently works three times the hours at half the pay he received when he launched his career in Seattle.

"Our biggest challenge to our growth is finding qualified physicians that want to come here and be willing to start at a reduced pay [while] understanding the long-term benefits," he said. "Since we have no support from the state or local government and are not backed by a hospital or federal grants, we try to be competitive in our salaries but frankly they are not, compared to what a new primary care physician can get on the Mainland, due to the high demand."

Duerler says he emphasizes to new recruits that pay does rise over time, and some private practice doctors on the Neighbor Islands eventually "do very well" in take home pay, though it may take several years.

Transparency

The cost of medical services can vary drastically, depending on your coverage and clinic of choice. The same CAT scan could cost $250 at one clinic and $50 at another. Because of this disparity, there's a push for transparency in costs.

At times, even primary care physicians may not be clear on costs, Loengard said.

"They have a perception of care their colleagues provide, but they have no idea what the cost is, so I think there is a lot of interest in having a greater understanding of that," she said.

Patients at clinics like Waikiki Health are particularly interested in health care costs. Knowing the bill can make or break a choice to get a procedure, Ahuna says.

"They want to know, 'how much is this going to cost,' and that affects referrals even, because they say, 'I don't want to go to that doctor, because I can't afford the co-pay, and I'm not sure if I really need it,'" she said. "It affects us on all levels."

Because the clinic is a certified "patient-centered medical home," after-visit clinical summaries are required, and that can sometimes cause issues, she said.

"Transparency is double-edged, because they want to know all of it, what their diagnoses are, and we're required to share with them their lists and medications and that has helped with other medications, but at the same time, it takes a lot of time, because many want to discuss every single diagnosis."

Gladstone said Hawaii Pacific Health has an estimator tool for patients. The tool works for planned procedures, but emergency visits will always be difficult to itemize, he said.

The Hawaii Health care Project

The public-private partnership between the Office of the Governor and Hawaii's healthcare industry has identified six ways in which the Hawaii health landscape could improve.

- **Primary Care practice redesign:** Ensure Hawaii residents effectively utilize and enroll in patient-centered medical homes, and incorporate a renewed attention to behavioral health issues to target the most effective care. Patient-centered medical homes use a team approach to care, with patients at the center of attention. The Hawaii Healthcare Project wants to enroll 80 percent of Hawaii residents in a PCMH by 2017.
- **Health Information Technology:** Connect those involved in Hawaii's health care "ecosystem" and utilize data-backed and proven delivery and payment models.
- **Care coordination:** Launch programs that target high-risk/high-need populations. Medicaid Medical Homes and Community Care Networks are in the pilot phase and are projected to serve 30,000 people.
- Workforce development: Broaden opportunities for "team-based care," address workforce shortages and improve cultural competency of providers.
- **Payment reform:** Transition all payers to value-based purchasing.
- **Policy strategies and levers:** Align state resources to drive policy change.

Source: The Hawaii Healthcare Project, Hawaii Institute for Public Affairs

Top challenges for the Hawaii health industry today:

- Harmonizing the Hawaii Prepaid Health Care Act and the federal Affordable Care Act
- Learning to switch focus to quality over quantity
- Empowering patients
- Measuring patient outcomes
- Collecting data
- Consolidating electronic health records
- Attracting physicians

PBN reporters Darin Moriki and Duane Shimogawa contributed to this story

A NOTABLE PASSING…*by Dr. Dennis G. Rhatigan*

Dr. Lawrence J. Connors, born June 1, 1929 in New York, died September 20, 2015 in Kailua, Hawaii.

He was ordained as a Maryknoll priest in 1956 and worked as a missionary priest in Taiwan for 14 years. In 1973, he left the priesthood and married Betsy Rhatigan.

He attended Columbia Institute of Chiropractic in New York City. He graduated in 1977 and during a cold winter, they decided to investigate a place that Larry visited during a layover in Honolulu years earlier. That place was Kailua beach.

In April 1977, he passed the Hawaii state boards. He befriended Dr. Steve Boggs who was very helpful in finding housing and transportation. He also introduced Larry to the state association. At that time, there were two associations, straight and mixer.

Larry found his first job here as an associate with Dr. Larry Eustace on Keeaumoku St. In time, he became president of the former Hawaii Chiropractic Association. He was instrumental in merging the two associations and was the second president of the new merged Hawaii State Chiropractic Association.

His intelligence and mediation skills were critical in the merger, which persists today. In 1978 he opened his practice in Kaneohe, Family Chiropractic Center. It grew to include multiple associates, a therapeutic massage center and a physical therapy rehabilitation center.

He was a mentor to a good number of local chiropractors. He had been comfortably retired for the past several years. He leaves behind his wife Betsy, four children and four grandchildren.

To add a personal note that the young doctors might appreciate: While I was staying at his home in the early '80's, I was doing some house repairs and I hurt my back. When he came home after a long day at work, I asked him if he had the energy and wouldn't mind doing one more patient adjustment on me. He smiled and said; "I always have the energy for one more adjustment! I think it is the best thing I can do for another human being!" That's what he believed and that's how he lived.

LEGISLATION WOULD INCLUDE CHIROPRACTIC PHYSICIANS IN U.S. PUBLIC HEALTH SERVICE

A new bill in the U.S. House of Representatives would improve the quality of America's health care infrastructure by further integrating doctors of chiropractic (DCs) through the nation's official delivery and research networks. H.R. 3851, introduced by Rep. Gene Green (D-Texas), calls for the appointment of chiropractic physicians as officers in the U.S. Public Health Service (USPHS) Commissioned Corps.

"A top priority of the American Chiropractic Association (ACA) has always been to increase access to and utilization of chiropractic services available through the federal government," said ACA President Anthony Hamm, DC. "The services of chiropractic physicians will be a tremendous value to the Public Health Service's Commissioned Corps, and enacting this legislation will be another important milestone in the mission to fully integrate chiropractic care into the nation's health care delivery system."

H.R. 3851 would include DCs in the USPHS Regular Corps and the Ready Reserve Corps, and would require the president, in consultation with the Surgeon General and the U.S. Secretary of Health and Human Services, to appoint no fewer than six DCs to the Commissioned Corps.

Although the USPHS Commissioned Corps includes representatives from many diverse health care professions, no DCs have ever been appointed to serve.

"Chiropractic physicians already serve our nation's active-duty military and veterans with distinction," said Dr. Hamm. "H.R. 3851 will allow DCs to join forces with other health care providers in the fight against disease, poor health conditions and other threats during both non-emergency and emergency periods for our country. We extend our appreciation to Rep. Green for his effort to introduce this long-overdue legislation."

USPHS is an elite team of more than 6,000 full-time, well-trained, highly qualified public health professionals dedicated to delivering the nation's public health promotion and disease prevention programs and advancing public health science. As one of America's seven uniformed services, the Commissioned Corps fills essential public health leadership and service roles within the nation's federal government agencies and programs. Officers in the Corps provide health care services in a variety of locations and venues, including care to members of the U.S. Coast Guard and at community health centers.

WHAT EVERY HAWAII DC SHOULD KNOW

By Dr. Gary K. Saito, DC, Immediate Past President, HSCA

Fraud and Abuse Part 1

We were surprised by the number of phone calls we got from our doctors after the last newsletter. Mostly, docs were expressing surprise that there are practice behaviors that they didn't know are against the law…against several laws, actually, so let's start clarifying some of them to keep our practitioners out of trouble.

It is crucial to understand these laws not only because following them is the right thing to do, but also because violating them could result in criminal penalties, civil fines, exclusion from the Federal health care programs, or loss of your license.

Let's start with violations of Federal laws. This advisory is put out by the Federal Office of the Inspector General, Department of Justice, Department of Health and Human Services, and CMS (Medicare & Medicaid Services).

The **Anti-Kickback Statute** is one of the most important fraud and abuse laws that apply to physicians. It is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals to your office or to generate business for any service payable by federal health care programs, including the Medicare Program. Remuneration includes anything of value and can take many forms besides cash. In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime. The statute covers both the payers and the recipients of the remunerations.

Under the Civil Monetary Penalties Law (CMPL), physicians who pay or accept kickbacks also face penalties of up to $50,000 per kickback plus three times the amount of the remuneration. (There is a small window called a safe harbor that might protect you, see "OIG's Safe Harbor Regulations")

Many people and companies want your patients' business and would pay you to send that business their way. Just as it is illegal for you to take money from providers and suppliers in return for the referral of your Medicare patients, it is illegal for you to pay others to refer their Medicare patients to you.

Also important: Where the Medicare program requires patients to pay copays for services, you are generally required to collect that money from your patients. Routinely waiving these copays could implicate the Anti-Trust Statutes and it is also a violation if you advertise that you will forgive copayments. However, you are free to waive a copayment if you make an individual determination that the patient cannot afford to pay or if your reasonable collection efforts have failed. NOTE: It is legal to provide free or discounted services to uninsured people.

This article was excerpted from: http://oig.hhs.gov/compliance/physician-education/01laws.asp or you can search "Stark Laws" or "Fraud and Abuse" to get a library of information from many sources.

FRAUD AND ABUSE PART 2

What is health care fraud and abuse, anyway? Here is a simple guide.

Fraud is an intentional deception or misrepresentation of fact that can result in unauthorized benefit or payment. Examples of Fraud are:

- Submitting claims for services not provided or used
- Falsifying claims or medical records
- Misrepresenting dates, frequency, duration or description of services rendered
- Billing or services at a higher level than provided or necessary
- Falsifying eligibility
- Failing to disclose coverage under other health insurance

Abuse means actions that are improper, inappropriate, outside acceptable standards of professional conduct or medically unnecessary. Examples are:

- A pattern of waiving cost-shares (copays) or deductibles
- Failure to maintain adequate medical or financial records
- A pattern of claims for services not medically necessary
- Refusal to furnish or allow access to medical records
- Improper billing practices

There are many types of fraud and abuse, as you can see. A practitioner can be charged with more than one type or incident of fraud. Typically, when an issue of fraud is discovered, the practitioner will be subject to additional scrutiny. Often, more examples of fraud or abuse are revealed in the investigation.

FRAUD AND ABUSE PART 3

We've said this over and over, and at the risk of being redundant, we will do it again because it is so important, and will be more important from October 1 this year.

Medicare is a Federal health care program. As such, all Stark laws apply to it and all chiropractors must abide by these federal guidelines.

We say again, chiropractors CANNOT opt out of Medicare. Medical doctors can, we can't. Every chiropractor in the country is subject to Medicare rules and regulations.

Being "non-participating" is not the same thing, and is not an opt-out. All it means is that you do not participate because you do not treat any Medicare patients. Too many of our doctors believe that their choice to be non-par gives them the right to treat Medicare patients and bypass all Medicare rules. If you treat a Medicare patient and do not report the encounter to Medicare, you can be cited. If you charge a Medicare eligible patient a treatment fee that is larger than what would be their co-payment, you can be cited for both fraud and abuse.

The only way to avoid Medicare regulations is simple: DO NOT TREAT ANY MEDICARE ELIGIBLE PEOPLE. While most Medicare recipients are 65 years or older, many, many other people qualify for Medicare for a wide variety of health reason. A Medicare recipient could be a teen-ager. You must ask every patient if they qualify for Medicare. If they do, you have only two choices.

1) If you don't want to deal with Medicare, you must not treat this person. Refer him/her to another practitioner who does Medicare. If you treat a Medicare patient, you MUST report each and every encounter with the patient to Medicare. You cannot treat the patient without informing Medicare.

(*If you treat a Medicare patient without reporting it, you will be subject to all the rules and regulations surrounding ICD-10 implemented October 1, 2015. Failure to do so can result in federal criminal charges and hefty monetary penalties. If the infraction is severe enough or extensive enough, you can lose your license to practice, not only in Hawaii but elsewhere*.)

2) If you treat a Medicare patient, you must record the patient's Medicare number. You must maintain proper documentation standards as described in recent ICD-10 lectures and webinars. You must bill Medicare and you must collect the appropriate patient co-payment. Failure to do any one of these can trigger an investigation, not only of this patient, but other patients of yours who are over 65 years of age. If it is found that you treated Medicare eligible beneficiaries without using proper protocols, you will face federal actions.

The reason it is not worth flirting with Medicare rules is that investigations can go beyond the patient in question and can result in a review of your records going back several years. Any and all violations of federal regulations will not be bundled into one fraud action, but each individual infraction (each patient and each encounter for care) can be fined separately, resulting in a very large cumulative monetary fine.

Although we are not aware of any large investigations in Hawaii leading to fines or license removals for the reasons stated above, under the new ICD-10 guidelines, there could be more aggressive actions taken to find fraud and abuse.

Final word: Starting October 1, 2015, there will be a greater demand for specificity, description, and completeness in our clinic records. The better your documentation is, the better it will serve to defend you. If your clinic records are sparse, incomplete, or absent, you will be vulnerable to the scrutiny of Medicare reviews. Learn all you can about ICD-10 and what will happen on October 1, 2015.

ICD-9 VS. ICD-10 BILLING GUIDELINES EFFECTIVE OCTOBER 1

ICD-10 IMPLEMENTATION IS DATE OF SERVICE DRIVEN

- Claims cannot contain both ICD-9 codes and ICD-10 codes
- Patients with claims requiring an ICD-9 code and claims requiring an ICD-10 code must be submitted separately
- Claims submitted with date(s) of service prior to October 1, 2015, must contain appropriate ICD-9 code(s)
- Claims with date(s) of services on/after October 1, 2015, must contain appropriate ICD-10 code(s) only. If claim includes an ICD-9 code, it will deny as unprocessable. Providers must submit a new claim that contains appropriate ICD-10 code(s)

ACA LAUNCHES NATIONAL CAMPAIGN FOR MEDICARE EQUALITY

ACA has launched a national grassroots effort to eliminate a blatantly anti-competitive provision of Medicare law that arbitrarily limits reimbursement for medically necessary services delivered by doctors of chiropractic (DCs). The campaign will generate signatures on a petition to the White House and members of Congress demanding that Medicare beneficiaries have full access to and reimbursement for a broader range of covered DC services.

This national grassroots campaign designed to achieve full physician status in Medicare -- an effort that seeks to correct the long-standing arbitrary and discriminatory limitation on our ability to be reimbursed for all necessary services that fall within individual state scopes of practice.

ACA's launch of this campaign comes after many years of intensive behind-the-scenes efforts that sought to convince CMS to issue regulatory changes that would address many of our concerns and those of Medicare beneficiaries. After many hours of work by both staff and volunteers, resources allocated and detailed supportive information repeatedly presented to CMS -- the non-responsiveness of that agency clearly reflects an unreasonable bias against our profession. While we will continue to dialog with CMS and press our concerns regarding a number of issues of vital importance to us, we are now prepared to take our concerns directly to Congress, and we are determined to do so in in an ongoing and highly robust fashion that will ultimately replace an archaic law.

In many respects, the success of our campaign will depend on your ability to reach out to your fellow DC's and others within the profession so that we can marshal the profession-wide support needed to sustain the grassroots lobbying needed to pressure Congress into taking action. We can focus our efforts on getting our patient's to sign the **"Medicare Equality Petition".**

At this point, we are placing an emphasis on distributing, via all available means, our **"Medicare Equality Petition"**

and the gathering of patient names, emails and contact information we can add to our national grassroots database.

The Hawaii State Chiropractic Association will be working with the ACA to once and for all FIX the Medicare problem. Please see a copy of the petition enclosed in this newsletter. Make duplicates and have your patients sign it! Or go online and sign up instantly:

www.acatoday.org/NMEP/nmep_signup.cfm

FAX a signed copy of the petition to ACA: (703) 243-2593

>>>OAHU PRACTICE FOR SALE <<<<

Well Established & Hugely Successful Upper Cervical NUCCA Practice For Sale

The only Upper Cervical practice on Oahu (Only 3 in State)
Spectacular growth (2014 Collections of $484K/Profit$216K)
This CASH practice saw average of 69 new patients/month
Owner relocating to mainland & will stay for a first class transition to the new owner

Location: Downtown Honolulu, 1,500 sq. ft. office
Impeccably Furnished & Decorated
New Digital X-ray
Price: **$450K** (SBA financing for qualified buyers)
Contact: **Dr. Peseau at Epracticesales**
Call: **(800) 227-6603**
Email: drpreseau@epracticesales.com
Web: www.epracticesales.com

>>>>CHIROPRACTOR WANTED<<<<

For growing multi-office Oahu practice:

WANTED: **HIGHLY MOTIVATED DC...FULL-TIME POSITION**
REQUIRED: Must be ready to come in, learn fast, and contribute immediately.
Must be coachable & have excellent communication skills.
Must have HI License or soon to be licensed
TERMS: Competitive Salary commensurate with Experience. (Experienced doctors & New graduates invited to apply)
CONTACT: **Send Resume:** **tpchiropractic@gmail.com**

>>>>OFFICE SPACE AVAILABLE<<<<

WANTED: **ESTABLISHED CHIROPRACTIC OFFICE LOOKING FOR A THIRD INDEPENDENT DC TO SHARE SPACE**
EQUIPMENT: Two drop tables, One Activator Table,
Two Ergo Wave Tables
ChiroTouch EHR Software, & phone system
STAFF: Receptionist/Office Manager
2 Licensed LMT's / 2 Massage Rooms
PLACE: Chiropractic & Massage Center
(Kaimuki Shopping Center)
3221 Waialae Ave., Ste. 330, Hono., HI
CONTACT: **Dr Chris Piianaia, or Dr Michael Toyooka**
PHONE: **(808) 732-4626, (808) 735-8749**