Use Recent Audit Findings to Improve Documentation

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Seems like we’re always waiting for the other shoe to drop...

Under the Magnifying Glass

EXECUTIVE SUMMARY: CMS SHOULD USE TARGETED TACTICS TO CURB QUESTIONABLE AND INAPPROPRIATE PAYMENTS FOR CHIROPRACTIC SERVICES

WHY WE DID THIS STUDY

Under the Magnifying Glass

CMS SHOULD USE TARGETED TACTICS TO CURB QUESTIONABLE AND INAPPROPRIATE PAYMENTS FOR CHIROPRACTIC SERVICES

Under the Magnifying Glass

Quarterly Review-Railroad

Pommette GSK Railroad Medicare has completed a widespread review of specific Chiropractic services for the time period between April and June 2017. The review sample included the CPT codes 96940 (Chiropractic Manipulative Treatment (CMT), Spinal, 1 region), 96941 (CMT, Spinal, 2 regions) 96942 (CMT, Spinal, 3 regions) and 96942 (CMT, Spinal, 5 regions). A total of 11,878 services were included in the sampling. Of the claims reviewed, 5,565 services were denied, and 6,313 services were allowed. The overall claim denial rate was approximately 46.7 percent based on the dollar amount billed. An analysis of the results is provided below.

<table>
<thead>
<tr>
<th>CPT codes</th>
<th># of Services Reviewed</th>
<th>Services Allowed</th>
<th>Services Denied</th>
<th>Error Rate % by Dollar Amount</th>
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<tbody>
<tr>
<td>96940</td>
<td>9,186</td>
<td>3,615</td>
<td>5,571</td>
<td>36.3</td>
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<tr>
<td>96941</td>
<td>11,812</td>
<td>3,393</td>
<td>8,419</td>
<td>47.2</td>
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<td>96942</td>
<td>361</td>
<td>176</td>
<td>187</td>
<td>55.1</td>
</tr>
<tr>
<td>Overall</td>
<td>13,679</td>
<td>8,179</td>
<td>5,500</td>
<td>46.7</td>
</tr>
</tbody>
</table>

The overall error rate for the quarter is 46.7 percent which is improved from last quarter’s error rate of 61.6 percent.
Let’s Take a Poll!

9

Is All Care Medically Necessary?

**Clinically Appropriate Care**
- Maintenance care
- Supportive care
- Palliative care
- Life enhancing and wellness care
- Symptom relieving only
- Care that doesn’t have as its goal improved function and correction

**Medically Necessary Care**
- Acute problems
- Care that can provide measurable functional improvement
- Chronic care with expected functional improvement
- Often defined by the carrier’s medical policy

Medical Necessity: Per Medicare

**Acute and Chronic Subluxation**
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 examination (PART)

Case Management is the Ticket

- When a payer is considering a service for reimbursement, they want to be sure SOMEONE is managing the patient’s care
- Is the condition “fixable”?
- Is there any more improvement to be expected?
I know they need care...now what?

Is the condition likely to be treated as an INCIDENT, BURST or EPISODE?

- Is there a treatment plan or a medical necessity? (NO) = AT
- Is the treatment plan or medical necessity of the patient documented? (YES) = GA

This is the $64,000 Question

Is this visit AT or GA worthy?

- If the visit is inside a Treatment Plan/Active Episode of Care = AT
- If the visit is outside a Treatment Plan/Active Episode of Care = GA (and requires use of ABN form)

Error Rate Needs to Come Down

Let’s Follow the Simple “YES” Path
Let’s Follow Alt. 1 “YES” Path

CONSIDER: Is the patient a PPS case or a non-PPS case?

FIND OUT: Is a condition exacerbation or new injury reasonably related to an AT intervention?

OUTCOME: Co-exists with an AT intervention (if no, refer to step 1 for non-AT intervention)

Let’s Follow Alt. 2 “YES” Path

CONSIDER: Is the patient a PPS case or a non-PPS case?

FIND OUT: Is a condition exacerbation or new injury reasonably related to an AT intervention?

OUTCOME: Co-exists with an AT intervention (if no, refer to step 1 for non-AT intervention)

Let’s Go Down the True Non-AT (GA) Path Part One

CONSIDER: Is the patient a PPS case or a non-PPS case?

FIND OUT: Is a condition exacerbation or new injury reasonably related to an AT intervention?

OUTCOME: Co-exists with an AT intervention (if no, refer to step 1 for non-AT intervention)

Let’s Go Down the True Non-AT Path “Part Two” No Thank You

CONSIDER: Is the patient a PPS case or a non-PPS case?

FIND OUT: Is a condition exacerbation or new injury reasonably related to an AT intervention?

OUTCOME: Co-exists with an AT intervention (if no, refer to step 1 for non-AT intervention)

DCs Must Answer with Certainty!

Is there a subluxation present, capable of causing a significant neuromusculoskeletal (NMS) condition, and does the patient have a documented loss of function that can be improved?

If No....

In this circumstance, per Medicare coverage requirements, medical necessity cannot be established and therefore the condition is likely maintenance care.

Improper ABN Usage

Review Rationale:
The submitted documentation did not support the diagnosis of subluxation, either through the presence of radiologic testing 12 months prior or three months following initiation of treatment, or by physical examination documenting abnormal range of motion or any asymmetry/imbalance. (CMS Pub 100-02 Medicare Benefit Policy Manual, Chapter 15, § 440.1.2, LCD L34816)

The item(s) or service(s) under review has been denied for reasons other than specified on the Medicare Advance Beneficiary Notice of Noncoverage (ABN) submitted for review. Liability may only be shifted to the beneficiary if the ABN accurately specifies the expected reason for denial and if that specific reason turns out to be the actual reason for denial. Therefore, financial responsibility for the noncovered Medicare item(s) or service(s) rests with the provider/supplier and the provider/supplier may not seek payment for the noncovered item(s) or service(s) at issue from the beneficiary. (Pub. 100-04, Medicare Claims Processing Manual Chapter 30, § 110.5.2)
Clarify Once and For All...

Hint: ABN forms are mandatory when a CMT service may not be medically necessary

It is up to the doctor to direct the team member on when the visit may be considered maintenance rather than active treatment (AT)

As with the previous discussion, it has to be ONE or the OTHER!
Let's Follow the “YES” Track

Keep in mind that not every patient will agree to pay for GA care

Proposed/Draft Process Information
Synopsis of Changes

Changes

No significant changes in coverage, provided American Chiropractic Association (ACA) approved and supported clarity to the Internet Only Manual (IOM) requirements and the documentation needed to support Chiropractor claims. ACA intends to utilize this policy to educate their members.

Noridian Leading the Way

New Information Is Being Added for Clarity

Strategic Health Solutions
Independent Reviewer
Really? Don’t Bet on It!

Noridian Proposed

Medicare Documentation Guidelines

Initial Visit

- History
- Description of Present Illness, including functional deficit(s)
- Proof of Subluxation
  - PART or X-ray
- Physical Exam (PART)
- Assessment & Diagnosis
  - 1st Subluxation
  - 2nd Condition
- Treatment Plan
- Date of initial treatment

Subsequent Visits

- History
- Review of chief complaint
- Physical Exam (PART)
- Document daily treatment
- Progress related to treatment goals/plan (Assessment)

No Mention of Aggravating or Relieving Factors
No Mention of Prior Interventions

It’s Always Been Part of the Rules

Initial Visit

- Description of the present illness including:
  - Symptoms causing patient to seek treatment
  - Mechanism of trauma
  - Quality and character of symptoms/problem
  - Onset, duration, intensity, frequency, location, and radiation of symptoms
  - Aggravating or relieving factors
  - Prior interventions, treatments, medications, secondary complaints

2. History Requirement

- A Natural Part of Intake History

Initial HISTORY:

- Chief Complaint: Acute pain in the back of the neck since 10/29/2016.
- Mechanism of Injury: Within two hours of performing yardwork
- Frequency/Quality: Constant discomfort described as aching, deep and sharp
- Radiation of Symptoms: Radiating to back of left upper arm
- Change in Complaint/VAS: Complaint has worsened since the onset and the pain scale is presently rated 8/10 (10/10 being most severe)
- - Modifying Factors: Relieved by heat packs and rest and aggravated by bending and lying down
- Previous Episodes: Denies past episodes
- Previous Care: Over-the-counter medications, Advil 2 tabs PRN
- Recent Diagnostic Tests: Denies recent diagnostic testing
- ADL/Functional Deficits: Explains homemaking has become difficult. Daily duties such as caring for family, grocery shopping and performing household chores is debilitating after only 5-10 minutes.
- Patient subjective goal(s): Explains personal goal for starting treatment is to have no functional limitations

History 1

Deconstructed History

- Initial History:
  - Mechanism of injury: Within two hours of performing yardwork
  - Frequency/Quality: Constant discomfort described as aching, deep and sharp
  - Radiation of Symptoms: Radiating to back of left upper arm
  - Change in Complaint/VAS: Complaint has worsened since the onset and the pain scale is presently rated 8/10 (10/10 being most severe)
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Ask Every Time as Part of HPI
### Medicare Documentation Guidelines

#### Initial Visit
- **History**
- Description of Present Illness - including functional deficit(s)
- **Proof of Subluxation**
  - PART or X-ray
- **Physical Exam (PART)**
  - Assessment & Diagnosis
    - 1st Subluxation
    - 2nd Condition
  - Treatment Plan
  - Date of initial treatment

#### Subsequent Visits
- **History**
- Review of chief complaint
- **Physical Exam (PART)**
- **Document daily treatment**
- **Progress related to treatment goals/plan (Assessment)**

### Lack of Demonstration of Subluxation

**Initial OV-Lays the Foundation**

1. **Evaluation of musculoskeletal/nervous system through physical examination.**
   - Pain/tenderness is evaluated in terms of location, quality, and intensity.
   - Asymmetry/abnormality may be identified on a structural or segmental level.
   - Range of motion abnormalities results from changes in active, passive, and accessory joint movements resulting in an increase or a decrease of structural or segmental mobility.
   - Tissue, tone, and temperature abnormalities are indicated by changes in the characteristics of associated soft tissues, including skin, fascia, muscle, and ligament.

**Recommended Codes:**
- CPT-4 Codes: 95911, 95912
- ICD-10 Codes: M54.01, M54.02, M54.04, M54.05
- ICD-10 Codes (that do NOT Support Medical Necessity)
- ICD-10 Additional Information

**Wide Open Range of DX Codes Available**
Common Errors We See

Routine Visits

Subsequent Visit Must-Haves

- 1(b) Changes since last visit might include any patient history information such as:
  - Patient reports higher/lower incidence of symptoms (i.e. pain frequency occurs less than 50% of day)
  - Patient reports increased/decreased ADL ability (i.e. less difficulty in standing for work)
  - Patient reports improving/worsening symptoms related to use of specific relieving factor (i.e. applied heat is easing muscle spasms)

Use Existing Personalized Info

1(c) System review if relevant:
- Review of any medical conditions or physical systems that might be affecting the spine or spinal condition being treated or systems that the treatment might be affecting. Examples might include:
  - Patient has osteoarthritis and reports a flare up with increase in pain and tension in joints.
  - Patient reports difficulty sleeping related to pain.

Clarified Expectations

Notation of Treatment Effectiveness

Subjective/Function Changes Since Last OV

Documentation of changes in the patient's examination, status, progression must be recorded at each visit.

The evaluation process must be an ongoing procedure. Signs and certain symptoms must be noted during the course of treatment to determine the success of the patient progress. Standardized measurement scales (e.g., Visual Analog Scale (VAS), Oswestry Disability Questionnaire, and the Quebec Back Pain Disability Scale) may be used to measure improvement or lack thereof. The ongoing evaluation and observation forming the basis for treatment modification is a key factor in proper management. "The initial examination no matter how thorough cannot be expected to provide all of the answers. A treatment plan should be instituted with the effects assessed to determine whether it should be continued or a different plan adopted. Moreover, it is the examiner that forms the foundation for treatment, guiding the doctor in selecting appropriate treatment techniques, frequency, and course of treatment.

Review Determination:
The claim for chiropractic services was paid in error. Adjustment or denial of the claim has been recommended to the Centers for Medicare & Medicaid Services (CMS).

Review Rationale:
For dates of service November 3rd, 4th, and 17th the submitted subsequent visit documentation did not meet the required Medicare guidelines. The documentation did not include notation of treatment effectiveness. (CMS Pub 100-2 Medicare Benefit Policy Manual, Chapter 15, § 240.1.2)
Assessment in Objective Findings

2 (b.) Assessment of change in patient condition since last visit.
- Assessment of the changes from exam on last visit to today's exam.

Doctor’s Assessment Drives Medical Necessity

2 (b.) Assessment of change in patient condition since last visit examples:
- Patient lower back pain decreased from 8 to 6.
- Lumbar ROM increased since last visit.
- Muscle spasms present in lumbar paraspinals, increased hypertonicity.
- Asymmetry continues to be palpable at L4-5.

Use Objective Measures to Track Effectiveness

2 (c.) Evaluation of treatment effectiveness.
- From the Initial Visit Guidelines, CMS establishes use of objective measures to evaluate treatment effectiveness. Examples are:
  - Pain scale – examples: VAS or 0-10 scale
  - ROM measures expressed as degrees.
  - ADL measures such as sleep increased from 4 hours to 5 hours per night.
  - Walking without pain increased from 10 minutes to 20 minutes.
- Each subsequent date of service should have an evaluation of treatment effectiveness using an objective measure.

Must Document Exact Vertebrae

Document the manual treatment given on the date of service. Examples are shown below:
- C2, T4, L5 received manual manipulation today.
- T3 and L4 manipulated with activator.
- Sacroiliac received treatment by Cox maneuver.
- Diversified treatment to C4, T2, L3 and sacrum.

ROV-1

3rd Party Note for One Complaint

Subjective
- Daily Encounter: Treatment for acute active care on 12/19 out of a projected 8 (Slight)
- Chief Complaint: Aching, deep, and sharp discomfort of the back of the neck
- Subjunctive Patient Assessment: Ustily stated this complaint improved since last visit
- ADL Change: Ability to perform household activities remains unchanged from last visit
- Current Functional Limitations: Caring for family, looking over shoulder and tying down
- Pain Scale: Document note for this complaint shows last encounter, at its worst it is rated 6/10 using verbal or visual analog scale

Objective
- Daily Objective Findings
  - Spinal Restriction/Subluxation(s): C4, C5, C6, C7, T1, T2, T3 and T4
  - Par/Tenderness: Nod to lower cervical
  - Postural Analysis: Head rotation left and right
  - Muscle Test(s): 3 out of 20 (several) off side of neck and left leg
  - ROM Concern(s): Cervical extension and cervical right rotation was recorded as moderately reduced with pain

ROV-2

Assessment

- Daily Assessment: Devoiding improvement; seeing expected as indicated in today's subjective and objective evaluation
- Current Functional Ability: Able to currently sit in chair on the telephone for 10 minutes and is on course to meet her short term goal of 20 minutes within all phases of the most recent treatment plan
- Determination of Care: Continued care is necessary to meet the goal
- Plan: Today's Treatment
- Chief Complaint: Consistent complaint described as achy, deep and sharp in the back of the neck
- Primary Treatment:
  - Cervical: Chiropractic Manipulative Therapy (CMT) to the right C4, right C5, right C6, right C7, T1 and T2 (light work)
  - Complementary adjustment(s) at levels: T1, T2, T3 and T4
  - no external (e.g. traction) adjustment today

Supportive Therapy
- To optimize treatment effectiveness, the following therapy(ies) were performed:
  - In-patient treatment plan: ESU (Electrotherapy) was applied to left side of neck and right side of neck, Region: for 40 minutes
  - In-patient treatment plan: Hot Pack: Hot moist pack applied to paraspinal (left) (right) and upper thoracic region(s) for 30 minutes

Assess:
- To Effect: Treatment rendered without incident and responding as expected
- Next Visit: Continue with treatment plan as assessed
**Significant Changes: ALL GOOD**

**Signature Guidelines**

**Let's Take a Poll!**
AUGUST 2016

“Establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, correctly coded and adequately documented.”

The Gospel According to KMC...
• “It’s ridiculous to think that in 2017 you can run the business of healthcare without a mandatory compliance program. It’s tantamount to thinking that you can adjust without going to chiropractic school.”

The Time Is Now to Protect Yourself with Simple Corrections and Changes!

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- Avoid common documentation errors and omissions
- Code when you address compensatory areas vs. treat primary subsections
- Install necessary HIPAA and OIG compliance policies

More info? KMCUniversity.com/LibraryPlusCompliance

"We are our choices."
- J.P. Sartre
Let’s Take a Poll!

Need Help?
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