Recordkeeping and Risk Management for 2018
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KMC University

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

FALSE CLAIM PENALTIES INCREASE AGAIN

On February 3, 2017, the Department of Justice (DOJ) issued a Final Rule to increase the civil monetary penalties assessed under the False Claims Act (FCA), due to inflation for the year 2017, to an all-time high of $10,657 (minimum) to $23,916 (maximum). Thirty years ago, in 1986, Congress amended the False Claims Act to provide the government with a more effective way of protecting against false claims and fraud in waste and abuse of federal resources used to fund healthcare programs like Medicare, Medicaid, and TRICARE. Continue reading.

WHAT HAPPENED?
$359 MILLION

Visit numbers increased...

Medical Necessity Decreased

WHAT HAPPENED?
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Should Chiropractic Visits Be Limited?

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Should Chiropractic Visits Be Limited?

WHAT HAPPENED?
$359 MILLION

Visit numbers increased...

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Should Chiropractic Visits Be Limited?
Lack of Medical Necessity
- Incorrect Coding
- Insufficient Documentation

$359 MILLION

OIG 82% ERROR RATE
105 CLAIMS

CMS 51.7% ERROR RATE
451 CLAIMS
STATISTICALLY VALID, RANDOM SAMPLE?

❖ Statistics can be made to prove anything…

“Say you were standing with one foot in the oven and one foot in an ice bucket. According to the percentage people, you should be perfectly comfortable.” —Bobby Bragan, 1963

KEEP PERSPECTIVE

$6.7\text{ BILLION}$

THE AGE OLD QUESTION

1895 Modern Chiropractic is Born

1897 Palmer School of Chiropractic

1902 1st Grad Class

1906 DD jailed for practicing without a license

1913 Kansas legalizes Chiropractic

CHIROPRACTIC GAINS MOMENTUM

EARLY 1960 – AMA CONCERNED ABOUT MEMBERS COOPERATING WITH CHIROPRACTORS

1960 AMA goal to eliminate chiropractic: Chiro are “stealing money” from MDs

1963 AMA organizes the Committee on Quackery

1966 AMA forbids MDs to associate, refer, hire or employ chiropractors

1969 AMA publishes official anti-chiropractic opinion and begins to widen its base of chiropractic haters to include other health related groups.

MEDICARE DOES NOT INCLUDE CHIROPRACTIC

1966 Medicare begins, does NOT include Chiropractic
1970'S CONTINUED THE FIGHT WITH AMA

1972 Chiropractic gets included in Medicare. Limited coverage.

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1980'S WAR ON CHIROPRACTIC

1980 AMA reverses position on chiropractic

"Nothing has changed!"

1983 Wilks loses

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SHERMAN ANTI TRUST ACT

1. Restraint of trade
2. Prohibit Monopoly

WILK CASE DRUDGES FOR MANY YEARS...

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1979 AMA Report UU

“Chiropractic may be a valid healthcare field, BUT, the AMA knows of no scientific Evidence to support spinal manipulation…”

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**MC Expansion of Chiropractic?**

1. Straights vs. mixers
2. Legal battle: AMA vs. chiropractic cont'd
3. The x-ray requirement was to limit chiropractic

**Wilk v. AMA - The Conclusion**

1987
Wilk WINS!
1998
OIG Report
1997 Balance Budget Act
Adds Utilization Guideline

**The Outcome?**

01
HCFA should vigorously oppose any movement to expand chiropractic coverage.
02
Should impose a 12 visit yearly cap on chiropractic service.

**Controls Used by MC and Other Payers**

1. Most common mechanisms of control
2. Utilization caps are the most successful
3. Fail to prevent payments for maintenance care

**The Outcome?**

01
Use of modifier to identify active care
02
Frequency edits to identify maintenance
**Utilization Limits for Chiropractic**

- 1999
  - Limit chiropractic visits to 12 per year!

**Payment Vulnerability Analysis**

- 2005
  - Limit chiropractic visits to 12 per year

**Inappropriate Medicare Payments for Chiropractic Services**

- 2009
  - Withhold payments and reform prepayment review for chiropractors that repeatedly fail documentation requirements.

**High Errors and Poor Documentation**

1. New modifier to distinguish episodes of care
2. Allow caps of chiropractic services
3. Withhold payments & review repeat offenders

**The Outliers Are Audited and Made Example**

- 2013
- 2014
- 2015
- 2015

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

**August 2015 – Busy Year!**

- CERT shows decreased of improper payments for last 5 years,
- Chiropractic improper payments went up!
**WHAT THEY FOUND**

- High visit #
- Maintenance
- High potential up coding
- Fraud
- Beneficiary sharing
- Unlikely # of services

**RECOMMENDATIONS**

1. Establish more reliable controls for chiropractic care

   Date of Initial Treatment

2. Develop and use measures to identify questionable payments

   FPS – Fraud Prevention System

3. Make sure MACs are using the Diagnosis Control

   Subluxation Diagnosis

4. Use the pre and post payment reviews to enforce visit caps under MACRA

   12 VISIT CAP

---

"Establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, correctly coded and adequately documented."
OCTOBER 2016

$359 MILLION

WHAT THEY RECOMMENDED

• Determine a reasonable number of chiropractic services that are necessary to actively treat spinal subluxation and implement a system edit to identify services for review in excess of that number.

WHAT THEY RECOMMENDED

• Determine whether there should be a limit for the number of chiropractic services that Medicare will reimburse; if so, take appropriate action to put that limit into effect, and implement a system edit to disallow services in excess of that limit.

WHAT THEY RECOMMENDED

• Improve education of chiropractors on Medicare coverage requirements for chiropractic services and the proper use of the AT modifier to ensure that only medically necessary chiropractic services are billed to Medicare.

WHAT THEY RECOMMENDED

• Specifically identify significant obstacles to developing a more reliable control for identifying maintenance therapy and work to establish such a control. (For example, CMS could determine a reasonable length for a chiropractic treatment episode and implement a system edit to identify services for review when the number of days between the date of initial treatment and the date of service exceeds that length.)

HOW DID CMS RESPOND?

• Regarding our first recommendation, CMS stated that the Medicare Access and CHIP Reauthorization Act of 2015 requires prior authorization for specified chiropractic services furnished on or after January 1, 2017, by a chiropractor whose pattern of billing is aberrant and for episodes of treatment that included more than 12 services. CMS stated that it will monitor the results of this effort and determine whether further action is warranted.
MACRA: PRE-PAY REVIEW

01 Pattern of billing is aberrant compared to peers.
02 Services denial percentage in the 85th percentile or greater.
03 Can obtain approval for multiple services at one time.

ENDING PRE-PAY REVIEW

1 If the secretary determines that the chiropractor has a low denial rate under prior authorization.
2 May reapply prior authorization medical review if aberrant billing and denial rate returns.

WHAT DO YOU THINK?

PROBLEM WITHIN CHIROPRACTIC?
STATISTICS BEING MANIPULATED?
CONTINUATION OF AMA CONSPIRACY IS CHIROPRACTIC IT'S OWN WORST ENEMY!

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.”

Good Documentation Tells a Story

HOW IS CARE DEFINED?

CLINICALLY APPROPRIATE CARE
MEDICALLY NECESSARY CARE
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?

Under the Magnifying Glass

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

**EXECUTIVE SUMMARY:** CMS should use targeted tactics to curb questionable and inappropriate payments for chiropractic services.

**DE-01-14-00209**

**WHY WE DID THIS STUDY:**

- To identify the highest rate of inappropriate payments among Part B services
- To identify the Centers for Medicare & Medicaid Services (CMS) Comprehensive Error Rate Testing (CERT) review process
- Medicare covers chiropractic services to improve function, which, when performed as “active treatment,” are covered.
- When further clinical improvement cannot be reasonably expected from ongoing treatment, past payments for Chiropractic Services to medicare beneficiaries for chiropractic services, such as physical therapy, are considered inappropriate.
- Additional Medicare beneficiaries should be considered when determining the appropriateness of payments for chiropractic services.

**CASE EXAMPLES:**

- A beneficiary received chiropractic services for back pain.
- The beneficiary’s condition was determined to be chronic and not responsive to further treatment.
- The chiropractic services were determined to be unnecessary and payments for the services were inappropriate.

**RECOMMENDATIONS:**

- CMS should use targeted tactics to curb questionable and inappropriate payments for chiropractic services.
- CMS should develop and implement strategies to reduce inappropriate payments for chiropractic services.
"Establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, correctly coded and adequately documented."

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**AUGUST 2016**

**MN: Chiropractic Per CMS**

**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)

If above not met or exceeded = Not Medically Necessary!

**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)

**AT vs. GA Modifier**

- Has to be a Doctor Decision
- Needs to be clarified in the Assessment
- Patient needs to understand the difference
- Definitely Gray Areas

**You Must Decide!**

- It is up to the office, not the patient, to determine whether the visit is medically necessary or not
- It’s a clinical decision
- It’s not a money decision

**You Must Decide!**
Not Medicare Only...

The concept of medical necessity, active episodes of care, and maintenance care are the same for any type of third-party pay situation.

Documentation

Is this a Medicare patient?

Let's Follow the Simple “YES” Path

Is this a Medicare patient?

Let’s Follow Alt. 1 “YES” Path

Is this a Medicare patient?

Let’s Follow Alt. 2 “YES” Path

I know they need care...now what?

This is the $64,000 Question

KMC University’s Medicare Decision Making Matrix

Use this flowchart to help determine whether a Medicare patient’s visit is acute or maintenance care. Follow the prompts to support your decision making for appropriate outcomes.

Documentation

Let’s Follow the Simple “YES” Path

KMCUniversity.com (855) 832-6562

Let’s Follow Alt. 1 “YES” Path

KMCUniversity.com (855) 832-6562

Let’s Follow Alt. 2 “YES” Path

KMCUniversity.com (855) 832-6562

www.kmcuniversity.com

03/11/2018

(855) 832-6562
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.

If YES...it’s time to plan...

HINT: Setting internal treatment protocols keeps you from reinventing the wheel with each new condition

Incident Protocols
• Documentation within CMT
• May not be necessary to provide E/M
• Keep up your PQRS
• Beware of incidents that happen once a month like clockwork

Burst may be the most common used

Typical Episode of Care
• Likely to require at least one re-evaluation
• Chronic diagnosis and significant lack of function

Incident
• History/Chief Complaint
• Mechanism of injury
• DASH visual analog score
• Exam/Physical findings/PART
• Measurable functional deficits
• PX plan, including STRATs
• Estimated discharge or re-evaluation date
• Formal E/M service necessary to establish medical necessity for this much care
It has to be one or the other...

HINT: All team members should understand what it means to be “in an active episode of care” in order to assist with in-processing.

Let’s Go Down the “YES” Path

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

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

ABN for Voluntary Use

You should only provide ABNs to beneficiaries for things Medicare does not pay. The ABN serves as proof that the beneficiary knew and understood they would not be reimbursed. The ABN also serves as an optional (voluntary) way to notify Medicare of their financial liability prior to providing care that Medicare does not cover. Medicare does not require you to issue an ABN in order to bill Medicare for an item or service that is not a Medicare benefit and never covered.

- When you issue the ABN as a voluntary notice, the beneficiary does not check an option box or sign and date the notice.

Voluntary Use = "MAY I?"

WHEN MAY I ISSUE AN ABN?

Voluntary ABN Uses

Medicare does not require ABNs for statutorily excluded cases or for services Medicare never covers. However, in these situations, you may issue an ABN voluntarily. Refer to the "What Claim Reporting Modifiers Do I Use?" section at the end of this booklet for information on claim modifiers associated with voluntary ABN use.
Auditing - Medicare Initial Visit Checklist

Keep in Mind...

- Any "no" answered means not enough documentation to support the guidelines
- Any spinal area not indicated in each of the subsections indicates not enough documentation to support the episode
History and Examination Prompts

SECTION 1: INITIAL HISTORY for a New Episode

- XX1 and XX2: History are insufficient to rule out conditions and/or complications
- There is a possibility that a new episode or one has been established such as an incident or providing activity that was reasonably made possible as part of the episode
- Initial complaints were established for these areas of the spine
- Initial complaints were established for these areas of the spine
- Check the spinal areas for which you’ve satisfied all three of the history areas above.  SECTION 1 SCORE: C T P S

SECTION 2: INITIAL EXAM for a New Episode

- These regions of the spine were examined/patients and documentation shows (PART) use and/or technical event
- This condition and/or initial complaint to determine the appropriate diagnosis for aRadiology in these areas
- Reports were provided for any radiology procedures, if applicable
- Check the spinal areas for which you’ve satisfied the applicable exam areas above.  SECTION 2 SCORE: C T P S

General Considerations and Scoring

General Initial Visit Considerations

- Documentation in initial, descriptive and underlying data
- Documentation in initial, descriptive and underlying data
- Documentation in initial, descriptive and underlying data
- Documentation in initial, descriptive and underlying data
- Review each section above and place the letter “L” in the right column that was used on every section above.
- Noavior of either section indicates the number of clinical episodes required for documentation. Remember, any “L” on the checklist indicates that you do not have enough documentation to require a new episode or initial visit per Medicare guidelines, one visit only in the episode cannot be determined.  C T P S

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
- 1° 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)

History 1

History 2

Deconstructed History

- Initial History
- Review of System (ROS)
- Review of System (Continued)
- Physical Exam (PART)
- Assessment & Diagnosis
- 1° Subluxation
- 2nd Condition
- Treatment Plan
- Date of initial treatment

Assessment and TX Plan Prompts

SECTION 3: INITIAL ASSESSMENT for a New Episode

- Initial consideration of patient history with such findings, a present to date the area of the spinal complaint and the need for treatment
- Includes initial complaints, functional factors that may have appeared separate and go on larger treatment limits
- Check the spinal areas for which you’ve satisfied both of the assessment areas above.  SECTION 3 SCORE: C T P S

SECTION 4: PLAN OF TREATMENT for a New Episode

- Begin the date of the treatment plan is complete, including duration and frequency for each area treated
- Undergo any examination date, whether for periodic evaluation or X-ray for back
- Specific measurements were used to begin the treatment process and will be used to evaluate treatment effectiveness
- Specific functional treatment goals (both long and short-term) are present that encompass each area of the complaint and evaluation
- Staff members involved in the treatment for these areas
- All activity performed the visit is documented for these goals
- Check the spinal areas for which you’ve satisfied all three of the plan of treatment areas above.  SECTION 4 SCORE: C T P S
History 3

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)

Examination 1

Examination 2

PART = What Does Medicare Require
Each visit must document subluxation/segmental dysfunction
- To Document Subluxation
  - P- Pain and Tenderness
  - A- Asymmetry/Misalignment
  - R- Range of Motion
  - T- Tissue tone changes
- Two (2) of PART are required
- One (1) must be either A or R
Medicare Documentation Guidelines

**Initial Visit**

- History
- Description of Present Illness including functional deficit(s)
- Proof of Subluxation
- 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)

Assessment = Dr. Thinking

Assessment = Diagnosis

Assessment = Case Management

Initial Assessment

- Interpret the facts – don’t add new facts
- The assessment is the place to record your professional opinions and judgments as to the patient’s diagnosis, their progress, and prognosis

Initial Assessment

- Use this area to really make your case to the reviewer or adjuster
- Your assessment must use the patient reporting, measurements, complicating and co-morbidity factors, test results, and any unusual circumstances to paint the clearest picture
Document More “Thinking”

- Easier and more fun to exam, test, and treat than to explain your thoughts
- Time to put on the metaphorical white coat
- Real Doctoring
- Why you went to school

Bad Assessment Examples

Assessment

Diagnoses as of the examination on 1/18/2016:
$13.8XXS Sprain of joints and ligaments of thoracic part of neck, sequela $16.1XXS Strain of muscle, fascia and tendon at neck level, sequela M99.01 Segmental and somatic dysfunction of cervical region M50.21 Other cervical disc displacement, high cervical region M54.2 Cervicalgia M69.32 Other cervical disc degeneration, mid-cervical region M99.03 Segmental and somatic dysfunction of lumbar region M51.28 Other intervertebral disc displacement, lumbar region M54.8 Lumbosacral region

Assessment is Not a DX

Bad Assessment Examples

An Assessment is Not a DX

Assessment

Diagnoses as of the examination on 1/18/2016:
$13.8XXS Sprain of joints and ligaments of thoracic part of neck, sequela $16.1XXS Strain of muscle, fascia and tendon at neck level, sequela M99.01 Segmental and somatic dysfunction of cervical region M50.21 Other cervical disc displacement, high cervical region M54.2 Cervicalgia M69.32 Other cervical disc degeneration, mid-cervical region M99.03 Segmental and somatic dysfunction of lumbar region M51.28 Other intervertebral disc displacement, lumbar region M54.8 Lumbosacral region

Assessment Gets Lost in the Sauce

- More for return: Daily for 2 weeks.
- Assesement refers to diagnosis for assessment.
  - Progress goals: Rule out other diagnoses, treatment objectives: The
  short term goals are to increase patient's functional ability to move
  and return to home.
  - Assessment gets lost in the sauce.
  - Clinician desires to see follow-up to assess outcome.

Assessment and Plan

In Details

- Cervicalgia
- Pain in shoulder
- Sore of muscle
- Case management factors
- Consideration of co-morbidities
- More than diagnosis
- Case management factors
- Consideration of co-morbidities
- Explaining why you think they need treatment

What is a Good Assessment

- More than diagnosis
- Case management factors
- Consideration of co-morbidities
- Explaining why you think they need treatment
Diagnosis Is Supported by a Thorough History and Physical Examination

- Examination is needed to substantiate Hx findings and to quantify condition w/ objective data
- Use exam to prove your Dx from history
- Positive Hx components become ortho/neuro/palpation exams
- Physical exam quantifies how right you were with your working Dx
- Exclusion may also contribute to diagnosis

Medicare Documentation Guidelines

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<thead>
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<tr>
<td>1° Subluxation</td>
<td><strong>Date of initial treatment</strong></td>
</tr>
</tbody>
</table>
Meet the Requirements

- Frequency and duration
- Treatment goals for each region/treatment to include long term goal
- An evaluation of treatment effectiveness measurement
- Date of the plan

Review Items with Highest Disability

- Walking, sitting, standing, sleeping, traveling, and pain intensity all = 4 points
- Choose one or more that are easily measured to set as functional goals for treatment

Use Tools to Help with Your Goal Writing

- Use OATs to assist with identifying functional limitations
- Use mnemonics as cues to assist with including all necessary elements
- Goals should ALWAYS be functional in nature

Use for Evaluation of Treatment Effectiveness

- Beginning Score: 70% Disabled
- Goal Score: 10% or Better

70% = Crippled

Use Tools to Help with Your Goal Writing

- Use OATs to assist with identifying functional limitations
- Use mnemonics as cues to assist with including all necessary elements
- Goals should ALWAYS be functional in nature
Standing and Sleeping
• Standing and sleeping most greatly affect patient’s ADLs
• Easily measured on a daily basis
• Easily tracked through treatment
• Easy for the patient to manage and report on

Standing and Sleeping
• Standing and sleeping most greatly affect patient’s ADLs
• Easily measured on a daily basis
• Easily tracked through treatment
• Easy for the patient to manage and report on

Treatment Plan Components

Therapeutic Procedures (97110-97546)
• Therapeutic Procedures are time-based codes for billing purposes
• The patient is ACTIVE in the encounter
• Requires direct one-on-one patient contact
• Documentation should include both the total time spent and the time spent doing each activity/exercise.
• Codes are billed per 15 min increments

97110 Therapeutic Exercise
• Therapeutic Exercise, each 15 mins. One or more areas
• Incorporates one:
  • Strength
  • Endurance
  • Range of motion
  • Flexibility
• Must show functional deficit in the above during examination

97112 Neuromuscular Re-education (NMRE)
• Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception
• Proprioceptive Neuromuscular Facilitation (PNF), Feldenkrais, Bobath, BAP'S Boards, and desensitization techniques
• Most likely indicated for neurological conditions

324 24
97530 Therapeutic Activities

- Dynamic activities to improve functional performance, direct (one-on-one) with the patient (15 minutes)
- Incorporates two or more:
  - Strength
  - Endurance
  - Range of motion
  - Flexibility
- Must show functional deficit in the above during examination

97150 Group Exercise Code

- Therapeutic Procedure(s), group, (2 or more individuals)
  - Once per encounter, not timed!
  - Some carriers do not cover at all

97124 Massage

- Passive procedure used for restorative effect
- Used for effleurage, petrissage, and/or tapotement, stroking, compression, and/or percussion
- Considered separate and distinct from CMT

97140 Manual Therapy

- Includes soft tissue and joint mobilization, manual traction, trigger point therapies, passive range of motion, and myofascial release.
- With CMT - must be in a separate body region
- May require a -59 modifier

Is This 97140 or 97124?

- When To Use 97140
  - To effect changes in soft tissues, articular structures, and neural or vascular systems
  - To address a loss of joint motion, strength, or mobility
  - Must be part of an active treatment plan directed at a specific outcome
  - Daily routine visit documentation should include progress toward those stated goals
When to Use 97124

- Used to improve muscle function, stiffness, edema, muscle spasms or reduced joint motion
- When treatment is friction based, relaxation type massage that is less specific than 97140

Timed Coding Rules

The Intersection of 15 Minutes and 8 Minutes

Guidelines for Timed Codes

CMS and the AHA have developed guidelines concerning timed codes. There is often confusion about what codes should be used for the documentation of pain modalities. The International Classification of Diseases (ICD) guidelines and the CPT guidelines for payers, however, are consistent in the belief that a timed code is appropriate for any pain modality that involves treatment that requires face-to-face contact by the provider and involves treatment beyond 15 minutes. The following guidelines are based on an explanation of how the face-to-face contact must be provided by coding authorities, since the payers have different guidelines that are not consistent with any national coding policy for time therapy services to make sure you understand the time-specific timed coding requirements.

Physical Medicine modalities and procedures are a significant source of revenue for most orthopedic offices. In order to properly bill and document these services, it is crucial to understand the different coding requirements for these services.

Timed Coding Rules

- **Supervised Modalities**
  - 97010-97028 do not require one-on-one contact by the provider.
  - Billed only once per encounter.
  - Are not time based for billing purposes.
  - Documentation should include the time spent on the modality.

- **Constant Attendance Modalities**
  - 97032-97039 require direct one-on-one contact by provider.
  - These are time-based codes for billing purposes.
  - Documentation should include total time spent.

- **Therapeutic Procedures**
  - (97110-97546)
  - Therapeutic Procedures are time-based codes for billing purposes.
  - The patient is active in the encounter.
  - Require direct one-on-one patient contact by provider of the service.
  - Documentation should include the time spent and procedure performed.
AMA/CPT Says “Each 15 Minutes”

Medicare’s “8-Minute Rule” Meets “15 Minute Rule”

• For time-based codes, you must provide direct treatment for at least eight minutes in order to receive reimbursement from Medicare
• CMS and CPT have clarified that any timed based service, provided on its own, is not billable if performed for less than 8 minutes

Timed Treatment Codes

• For a single timed code being billed in a visit:
  • Less than 8 min = 0
  • 8 up to 23 min = 1
  • 23 up to 38 min = 2
  • 38 up to 53 min = 3
  • 53 up to 68 min = 4
  • And so on

• For multiple timed codes provided in the same session, add up the total minutes of skilled, one-on-one, time based therapy and divide that total by 15
  • If eight or more minutes are left over, you can bill for one more unit
  • If seven or fewer minutes remain, you cannot bill an additional unit

6 Minutes of Therapeutic Exercise

• Do not bill any CPT code
• Threshold not met
• Document the chart to include the exercise performed and note it was 6 minutes of time spent

21 Minutes of Therapeutic Exercise

• Abdominal hollowing exercises = 12 minutes
• Cervical range of motion exercises = 9 minutes
• Total time = 21 minutes = 1 billable unit
• Note the chart with all services performed and time spent on each along with total time

28 Minutes of Therapeutic Exercise

• Lumbar isometric exercises = 13 minutes
• Lumbar stretching = 9 minutes
• Lumbar strengthening exercises = 6 minutes
• Total time = 28 minutes = 2 billable units
• Note the chart with all services performed and time spent on each along with total time
26 Minutes of NMR & 25 Minutes of Therapeutic Exercises

- 26 minutes of various proprioceptive strengthening exercises
- 13 minutes of lumbar stabilization exercises
- 12 minutes of lumbar stretching exercises
- Total time = 51 minutes = 3 billable units
- Documentation includes all services and time spent

51 divided by 15 = 3 with 6 left over
Did not make it to a fourth unit

10 Minutes of TherEx; 5 Minutes of Ultrasound and 5 Minutes of Manual Therapy

- 10 + 5 + 5 = 20 total minutes = 1 billable unit
- US and MT are each less than TE
- Bill where most time was spent
- Total time didn’t reach 23 minutes

Date of Initial Treatment

- Relates to beginning of this treatment episode
- First date provider evaluated patient
- Submitted in Box 14 on the CMS-1500 form
- Referred to in subsequent visit documentation

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)

S + O = A → P and PART

- SOAP
  - Documentation system for patient encounters
  - Best for daily visits
- PART
  - Required documentation for subluxation/segmental dysfunction
  - Many providers believe that PART is enough
How do each of these fit into our daily documentation?

Subsequent Visit - History

- Review chief complaint
- Changes since last visit
- ROS if relevant

Subjective = Pain and Tenderness

 Subjective/Patient Assessment: more stated this complaint has improved since the last visit. She reports her ability to function has improved significantly with decreases of symptoms with the complaint when she is sitting, standing, and lying down. G/T IO reported using the Visual Analog Scale.

Subsequent Visit – Physical Exam

- Examine area(s) of spine
- They want to see PART
- How has the PART changed due to treatment
- Presence or absence of subluxation (PART)
- PART documentation on EVERY visit!
Objective = ART

• Quantifies the Subjective
• Daily physical exam
• Gathers data for treatment

A= Asymmetry or Misalignment

• Observable region asymmetry (posture or scoliosis screening)
• Observed local asymmetry (static palpation)
• Antalgic posture
• Gait abnormalities
• Functional or anatomical leg length discrepancies
• Muscle atrophy and asymmetry.

R= Range of Motion Abnormality

• Active ROM (observed and estimated)
• Passive ROM
• Resisted ROM
• Segmental motion palpation
• Joint fixation (hypomobility)
• Joint laxity (hypermobility)
• Joint crepitus
• ROM measurements

T= Tissue Tone Changes

• Observable hypertonicity, spasm, hypotonicity, and atrophy
• Fasciculations
• Edema
• Bruising, discoloration
• Heat
• Muscle-tendon crepitus
• Muscle weakness
• Heat measuring instruments

Objective: Subsequent Visit - Assessment

Documentation needs to show what the doctor is thinking:
• Treatment effectiveness
• Assessment of change since last visit
  • How and Why
• What is the progress towards the functional goals?
Assessment

S (P)+ O (ART)= A
• **How** has the patient responded to treatment?
• **Why** do they need more care?
• Are they meeting goals?

N/C, Guarded, Improving is not enough!

**Assessment:**
Daily Assessment: showing improvement and meeting expectations as indicated in today’s subjective and objective evaluation.
- Current Functional Ability: Lily currently has the ability of lying down and talking on the phone for 15 minutes and is on course of meeting her short term goal of 60 minutes by 30 days from the most recent treatment plan.
- Additional Functional Ability: Lily currently has the ability of sitting and walking for 30 minutes and is on course of meeting her short term goal of 60 minutes by 30 days from the most recent treatment plan.
- Additional Current Functional Ability: Lily currently has the ability of walking for 30 minutes and is on course of meeting her short term goal of 60 minutes by 30 days from the most recent treatment plan.
- Determination of Care: Continued care is necessary to meet the goal.

Progress Toward Goals

• Can be unchanged
• Must be quantitative
• Function is the key

**Plan**
S (P) + O (ART) = A ⇒ P

Treatment is a result of
• S+O findings
• Your assessment that TX will help condition

Subsequent Visit - Treatment

• CMT
  • List spinal/vertebral areas adjusted that are MN
  • Include secondary areas of compensation that were treated
  • Include technique
  • Manual manipulation
  • Can include handheld device with manual force
  • How did patient handle the treatment
  • Passive/Active therapies
  • Document what was done, why it was done, and how it affected the patient

**Plan**

Required to be added:
- CMT
- List spinal/vertebral areas adjusted that are MN
- Include secondary areas of compensation that were treated
- Include technique
- Manual manipulation
- Can include handheld device with manual force
- How did patient handle the treatment
- Passive/Active therapies
- Document what was done, why it was done, and how it affected the patient

- Treatment demanded without incident and responding as expected
- Good form, continue with treatment plan as scheduled
ROV-1

3rd Party Note for One Complaint

Subjective

Daily Encounter: Treatment for acute/patients care on visit 3 of a projected 8 (MAR)

Chief Complaint: Aching, deep, and sharp discomfort of the back of the neck

Objective

Physician

Today’s Findings

• Spinal Restriction(s)/Subluxation(s): C3, C4, C5, C6, C7, T1, T3, and T6
• Pain/Tenderness: Not to lower cervical
• Neurologic: Head rotation left and right, left and right shoulder
• Muscle Spasm(s): 3 out of 5 (20) being mid-lower left side of neck and left thoracic

IM/OM(Cervical): Cervical extension and left side rotation reported as moderately reduced with pain rated 3/10.

ROV-2

Assessment

Daily Assessment: Sharing Improvement: Headching and eating activities are eliminated in today’s subjective and objective evaluation

Current Functional Ability: Life is currently able to be down and walk on the telephone for 15 minutes and is on course to meet her short-term goal of 60 minutes within 30 days of the most recent treatment plan

Determination of Care: Continued care is necessary to meet the goal

Plan

Today’s Treatment

Chief Complaint: Constant discomfort described as aching, deep, and sharp in the back of the neck

Primary Treatment: Shear/Force: Chiropractic Manipulative Therapy (CMT) to the right C5, right C6, right C7, T3, and T4. T1, T3, T4

Supportive Therapy: To continue treatment effectiveness with the following therapy(ies) were performed:

• As per treatment plan: TENS Unilateral current was applied to left side of neck and right arm at 1.5 Hz, during 20 minutes
• As per treatment plan: HOT-Pack: Hot moist packs applied to posterior cervical (neck) and upper thoracic regions for 20 minutes

Assessed: To Effect: Treatment rendered without incident and responding as expected

Next Step: Continue with treatment plan as amended

Policies and Procedures to Address THESE Risks

Confused by Discounting Rules?

• Dual Fee Schedules
• Improper Time of Service Discounts
• Inducement Violations
• Antitrust Statute Violations
• False Claims Act Violations

Coding

Today’s Focus

PATIENT FINANCIAL INCONSISTENCIES

Don’t Let Patient Financial Policies be your WEAKEST LINK
Definitions

1. Dual Fee Schedules
2. Improper Time of Service Discounts
3. Inducement Violations
4. False Claims Act Violations
5. Anti-kickback Statute Violations

Avoid Dual Fee Schedules
• Charging more to insurance companies than you do to cash patients
  - Illegal in many states
  - Misrepresents charges to carriers
  - False Claims Act violation
  - May violate provider agreements
  - Triggers investigations

Time of Service Discounts
• Discount based on bookkeeping savings
• May or may not be defined
• Often not defensible
• May not be permissible on Federally insured patients

Inducement Violations
• Per the OIG: “incentives that are only nominal in value are NOT prohibited by inducement law”
• No more than $10 per item or $50 in the aggregate annually
• Even one free examination, x-ray, or therapy is a risk

False Claims Act Violations
• Establishes liability when any person or entity improperly receives from or avoids payment to the Feds
• Prohibits “knowingly presenting or causing to be presented, a false claim for payment or approval
4. False Claims Act Violations

- Prohibits "knowingly presenting or causing to be presented, a false claim for payment or approval"
- Examples:
  - Waiving deductibles or co-payments and not reporting to carriers
  - Up-coding for higher reimbursements
  - Down-coding based on payer type

5. Anti-Kickback Violations

A person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary’s selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services may be liable for civil money penalties (CMPs) of up to $10,000 for each wrongful act. The statute defines “remuneration” to include, without limitation, waivers of copayments and deductible amounts (or parts thereof) and transfers of items or services for free or for other than fair market value.
Regulated Fees

- By agreement, these fees are “imposed”
- Take the patient, take the fee
- Not considered a “discount”
- CMT only for Medicare
- WC, No-Fault and PIP defined by state guidelines
Clear Understanding of Hardship Fees

• Do you need a hardship fee schedule?
• Your hardship agreement can co-exist with other fee schedules
• You must set the standard up front, have qualifying factors, and verify eligibility.
• Utilize a standardized form and system
Mistakes and Blunders

- What may NOT be financial hardship?
  - No insurance
  - High deductible
  - I don’t wanna pay that much
  - My other doctor didn’t charge my copays
  - Pulse and a spine
  - Don’t confuse it with what a general discount is!! That’s what CHUSA is for!

Co-Pay or Deductible Waivers for Hardship

- The waiver is not offered as part of any advertisement or solicitation;
- Waivers are not routinely offered to patients;
- The waiver occurs after determining in good faith that the individual is in financial need;
- The waiver occurs after reasonable collection efforts have failed.
What About Professional Courtesy?

• Who do you offer courtesy to?
• Staff?
• Other DCs? Clergy? Military?
• What about when insurance is involved?
• Is it in writing?

Define Your Policy

It is the policy of this office to only offer legal Professional Courtesy arrangements. In keeping our policy legal, we adhere to the following guidelines:

- The services listed below are offered to all members of the stated groups without regard to volume or value of referrals.
- May include only those services regularly offered by the practice.
- Are included in written policy and have been approved by top practice management.
- Cannot be offered to pay pay unless the insurance company paying the bill is informed in writing or there is documented and verified financial hardship.
- Does not violate anti-kickback laws or client submission rules and regulations.

We offer discounts to the following groups at the following levels:

- Staff members of [practice name] are offered $25 off their first visit.
- Disposable medical equipment, nutritional supplies, or other hard goods items are offered to staff members.
- Immediate family members of our staff are offered $10 off.
- The following are considered as [practice name] and are no longer eligible for discounts:
  - For the purpose of this policy, immediate family members are considered to be: [Define such as parents, siblings, spouses, etc.]
  - Fellow Chiropractic associations in our community are offered treatment in the office.
  - [Practice name] does not offer [list of additional discounts].

NOTE: In circumstances where auto accidents, worker’s compensation accidents, other personal injury or other medical/legal situations occur, where reporting actual fees is necessary, and the party seeking professional courtesy wishes to receive treatment at this office, the party may divide to opt out of this policy, and elect to be charged the full and actual fee at that time. The party will place into writing what the office is directed to do, and at that time the party would be responsible for and expected to pay for treatment in order to have them reported to a third party for medical/legal reasons.

Likewise, if the party who qualifies for Professional Courtesy wishes to use third party health insurance for any reason, they must opt-out of this policy, because the office will collect 100% of the copayments, co-insurance, and any other deductible, as well as any other patient.
you are FREE to choose, but you are NOT FREE from the consequence of your choice

Need Help?
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