



Presented by:  
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MCS-P, CPCO, CCPC, CCA

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Know the Messenger!

- Celebrating 40 years in the profession; 15 years owning KMC University
- 40 year chiropractic patient and advocate
- Triple Certified for your listening pleasure
- Wife, Mom, and Nana



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Let's Set the Tone: Reality Check

3



In Compliance or Not?

4

Your Passion is Also a Regulated Business



Documentation

5

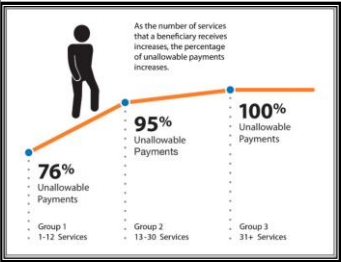
PORTFOLIO HIGHLIGHTS

- ! Medicare continued to make hundreds of millions in improper payments for chiropractic services.
- ! Chiropractic fraud, waste, and abuse is a concern.
- ! CMS's controls have not fully prevented improper payments.
- ! Establishing a medical review threshold for chiropractic services could save millions by reducing payments for medically unnecessary services without compromising beneficiary access to reasonable and necessary services.

Medicare Will Continue to Change

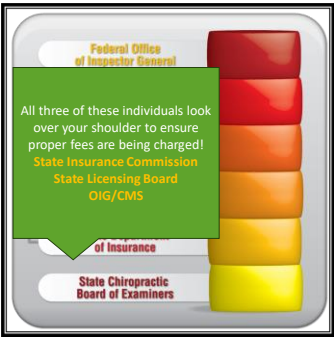
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Not Really  
Rocket  
Science



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Who is  
Watching?



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Who is the OIG?

Office of Inspector General's (OIG) mission is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries

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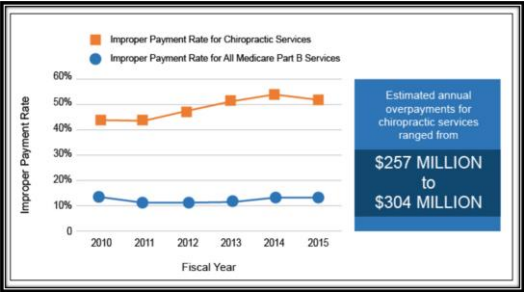
OIG Goal

"Critical to OIG's mission is fighting fraud, waste, and abuse...continue to employ a multi-faceted approach of prevention, detection, and deterrence.

- Identify, investigate, and act when needed
- Hold wrongdoers accountable and maximize recovery of public funds
- Prevent and deter fraud, waste, and abuse

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Chiropractic Track Record



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Table G1: Improper Payment Rates by Service Type: Part B

Part B Services (BETOS Codes)	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Lab tests - other (non-Medicare fee schedule)					
Office visits - established					
Specialist - other					
Minor procedures - other (Medicare fee schedule)					
Hospital visit - initial					
Hospital visit - subsequent					
All Codes With Less Than 30 Claims					
Ambulance					
Office visits - new					
Nursing home visit					
Ambulatory procedures - other	488	\$243,463,409	23.0%	10.4% - 35.6%	0.8%
Emergency room visit	184	\$233,323,950	13.5%	8.8% - 18.2%	0.7%
Other drugs	1,355	\$198,897,627	1.6%	0.8% - 2.5%	0.6%
Specialist - psychiatry	531	\$184,714,148	13.6%	7.2% - 20.0%	0.6%
Hospital visit - critical care	328	\$176,379,408	16.0%	12.2% - 19.8%	0.5%
Major procedure - Other	470	\$173,391,673	10.1%	(1.6%) - 21.8%	0.5%
Advanced imaging - CAT/CT/CTA: other	165	\$170,411,163	13.4%	2.8% - 24.1%	0.5%
Chiropractic	3446	\$161,340,228	30.3%	24.3% - 38.3%	0.5%
Other tests - other	969	\$156,512,209	11.6%	6.0% - 17.2%	0.5%

2022 Medicare Fee-for-Service Supplemental Improper Payment Data

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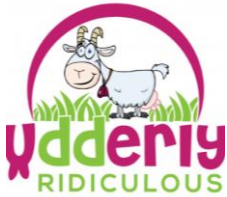
Table K3: Type of Services with Upcoding<sup>20</sup> Errors: Part B

Part B Services (RETOS Codes)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval
Office visits - established	\$397,844,411	2.7%	2.1% - 3.4%
Hospital visit - initial	\$302,583,878	12.2%	10.3% - 14.1%
Hospital visit - subsequent	\$210,421,447	4.2%	3.2% - 5.2%
Office visits - new	\$169,674,474	6.2%	4.9% - 7.5%
Nursing home visit	\$168,365,144	8.7%	3.5% - 13.9%
Emergency room visit	\$138,161,918	8.0%	5.4% - 10.5%
Hospital visit - critical care	\$130,372,194	11.8%	8.4% - 15.2%
Specialist - other	\$13,394,458	0.5%	0.0% - 1.0%
Dialysis services (Medicare Fee Schedule)	\$10,960,503	1.8%	(0.7%) - 4.3%
Echography/ultrasonography - other	\$7,750,441	1.3%	(0.9%) - 3.5%
Minor procedures - other (Medicare fee schedule)	\$7,281,197	0.2%	(0.0%) - 0.4%
Ambulance	\$6,551,198	0.2%	(0.1%) - 0.5%
Chiropractic	\$5,242,195	1.0%	(0.1%) - 2.1%
Ambulatory procedures - skin	\$5,103,915	0.2%	(0.1%) - 0.4%
Specialist - ophthalmology	\$4,147,234	0.2%	(0.2%) - 0.7%
Standard imaging - musculoskeletal	\$2,681,443	0.7%	(0.2%) - 1.6%
Specialist - psychiatry	\$2,522,204	0.2%	(0.1%) - 0.4%
Other tests - electrocardiograms	\$2,313,247	1.0%	(0.6%) - 2.0%

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The Gospel According to KMC...

“It’s ridiculous to think that in 2023 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.”



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OIG recommends Policies and Procedures to address these areas of risk



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Why Care About Financial Transactions in Healthcare?

- One of the most highly regulated issues
- One of the four areas OIG noted as worthy of focus

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Improved Compliance Also Brings Opportunities



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Why Implement a Compliance Program?

Integrate policies and procedures into the physician’s practice that are necessary to promote adherence to federal and state laws and statutes and regulations applicable to the delivery of healthcare services

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NOT JUST NO  
BUT HELL TO THE NO

OH  
HELL YEAH!!!

In or Out of Medicare?

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I GOT 99 PROBLEMS,  
AND MEDICARE COVERS THEM

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What's Different about Chiropractic?

- DCs can not "opt out" of Medicare
- DCs only have three covered services
- DCs must use subluxation DX codes along with a secondary
- DCs can't order any service other than CMT outside of the office
- DCs must document a subluxation on x-ray or with PART, but x-rays are not paid by Medicare for DCs

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**FACT SHEET**

**Opting Out of the Medicare Program**

**Q:** Are chiropractors allowed to Opt-Out of the Medicare Program?

**A:** No. By definition of the CMS CR 5426 the term "physician" is limited to doctors of medicine; doctors of osteopathy; doctors of dental surgery or of dental medicine; doctors of podiatric medicine; and doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the State in which such function or action is performed; no other physicians may opt out.

"The opt-out law does not define "physician" to include chiropractors; therefore, they may not opt out of Medicare and provide services under private contract. Physical therapists in independent practice and occupational therapists in independent practice cannot opt out because they are not within the opt-out law's definition of either a "physician" or "practitioner." (Rev. 62, Issued: 12-22-06, Effective: 11-13-06, Implementation: 04-02-07).

Source: <http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf>

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Not so fast...

I have forwarded your question to the EDI. They may reach out to you to provide information.

Regarding your question, Medicare providers are not allowed to provide services to beneficiaries but they can bill for services. Medicare does not reimburse a beneficiary directly if the provider is not enrolled. If you have any misinformed you may have received.

I will wait for your question. Thank you. Vicki

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Obligations of DCs When Agreeing to Accept and Treat Medicare Part B Patients

**Accept and Treat Medicare Part B Patients**

**NO**

**YES**

**Must be Properly Enrolled with Medicare**

**Must charge proper fee for excluded services**

**Must bill active treatment CMT on behalf of patient**

**Payor specific documentation required**

**Medical Necessity guidelines apply**

**Coding is based on documentation**

**Proper use of billing modifiers required**

**Not-Participating**

**Participating**

**Regulated limiting fees charged for CMT**

**Accepts allowed requested fee for CMT**

**May accept assignment on case-by-case basis for CMT**

**Always accepts assignment for CMT**

**The KMCU Financial System**

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Obligations of DCs When Agreeing to Accept and Treat Medicare Part C Patients

Accepts and Treats Medicare Part C Patients

NO

Not enrolled in any Part C Plan

Does not accept Medicare C patients for covered or non-covered services

Paying Out Of Pocket/Not Insured

Charge Part B allowed/limiting fee for active CMT. Implement a legal and compliant discount for excluded services

If submission not required, provide receipt/superbill for payments using proper coding

Follow State minimum and liability documentation requirements

YES

Non-Participating with Patient's Plan

Charge same as Part B for active CMT. Submission may be required - See verification

May elect to treat and bill proper directly. May become "deemed" provider

If submitting, must accept fee schedule

Paper specific documentation required

Medical Necessity guidelines apply

Coding is based on documentation

Proper use of billing modifiers required

Participating with Patient's Plan

Limited to the contracted fee for payment. Patient may still be responsible for excluded services

Must bill on behalf of patient

Paper specific documentation required

Medical Necessity guidelines apply

Coding is based on documentation

Proper use of billing modifiers required

The KMC University Financial

Billing

Documentation

Patient Finances

Compliance

Coding

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All Providers in the Group are Reassigned to One Tax-ID

**Associate Doctors, be aware!**

Physicians who reassign their right to bill and receive Medicare payments to their employer, by executing the CMS-855R application will still be held liable for false claims submitted by entities to which they have reassigned those benefits. Always know what is being billed under your provider number and name.

Medicare

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John Doe Chiropractic Clinic  
12345 Any Street, Anytown, AZ 12345  
(800) 123-4567890

**Carrier and Verification Reference Tool**

Name of Practice	Tax ID Number	Group NPI Number			

Name of Provider	Tax ID Number/SSN	NPI Number	PTAN		

Medicare Administrative Carrier (MAC) ☐ Participating ☐ Non-Participating

Medicare Carrier Name	Provider Services Phone Number	Interactive Voice Response Number	Carrier's Provider Web Address	Web Portal Login and Password

Medicare Advantage Plans

Advantage Plan Carrier Name	Provider Services Phone Number	Interactive Voice Response Number	Carrier's Provider Web Address	Web Portal Login and Password	Provider Name and D.I.	Per D.I. Mod-P1	Provider Name and D.I.	Per D.I. Mod-P2
						P-101		P-101
						P-101		P-101
						P-101		P-101
						P-101		P-101
						P-101		P-101

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Cash or Insurance?

Documentation

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The Real Why?

Documentation

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The KMC University's Guide to MEDICARE MODIFIERS

Modifiers Used Only With 98940, 98941, 98942	
Code	Description/Instruction
AT	Requiring At least Curative Treatment Indicates service rendered was medically necessary per Medicare guidelines
GA	Waiver of Liability (ABL) on file for mandatory use. Indicates maintenance care or visits related to maintenance care as required
GZ	Indicates you failed to collect ABL for maintenance care as required

Modifiers Used with All Statutorily Excluded Services	
Code	Description/Instruction
GY	Indicates statutorily non-covered non-service is rendered by a DC
GX	ABL on file for voluntary use
GP	Used for certain therapy services as part of outpatient treatment plan

MANDATORY SUBMISSION

VOLUNTARY SUBMISSION

Documentation

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Conduct Internal Audits

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Proactive vs. Reactive Audits

- Always better to proactively find issues vs. having them found for you
- Audit could be a simple review
- Reactive audits are no fun and could cost you a ton of money

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Why Perform Self-Audits?

- To identify and correct weaknesses in the patient record documentation to prove intent for being compliant
- To catch errors before they are billed
- To achieve constant improvement

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Baseline Audits

**Baseline audits** are preliminary assessments to develop a reference point for risk. By performing an **audit** in advance, your practice will identify improper billing and coding practices and make necessary corrective actions prior to any government or third-party payer **audit**. Includes the process of getting the beginning level of statistics as a baseline.

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Benefits of Baseline Audit

- Identify coding/documentation problems and fix them before they get out of hand
- Find ways to increase revenue by finding faulty systems
- Establish a beginning level of risk for your practice
- Create a list of significant goals for improvement and time period to achieve those goals
- Ultimately offer better care to your patient

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Compliance Officer or Contact Usually Performs Audits

Initial Baseline Audits  
More Effective if  
Performed by Outside  
Entity

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Review E/M and NP Ratios

Evaluation and Management (E/M) Codes			
	Total	Total by Category	Ratios by Category
99201	0	1110	0.00%
99202	0		0.00%
99203	1110		100.00%
99204	0		0.00%
99205	0	1377	0.00%
99211	0		0.00%
99212	3		0.22%
99213	1374		99.78%
99214	0	996	0.00%
99215	0		0.00%
99241	0		0.00%
99242	996		100.00%
99243	0	0	0.00%
99244	0		0.00%

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What Could Be Wrong?

- Lack of appropriate number of re-evaluations to prove medical necessity
- Number of NP E/M services vs. NP in statistics could reveal free services
- Re-evaluations for new episodes could be lacking

	Total	Total by Category	Ratios by Category
Chiropractic Manipulation			
98940	1283	36082	3.56%
98941	34799		96.44%
98942	0		0.00%
98943	668	668	1.85%
S8990	0	0	

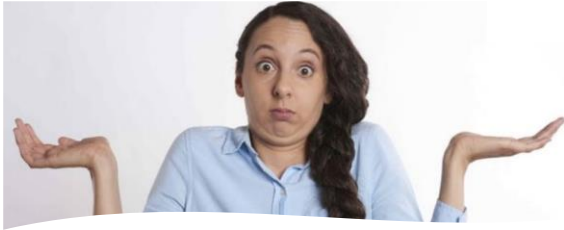
CMT Ratios Tell the Tale

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Who Was the Provider?

Scenario	Q5	Q6	Other Option
A DC (regular physician) is going on vacation for 10 or more days. Another local DC (substitute physician) is going on vacation next month for three days.	On the regular physician's 1500 Claim Form enter code <b>Q5</b> modifier (service furnished under a reciprocal billing arrangement, similar to a swap-out) in box 24D. (See Fig. 3.)	Do not use this modifier unless the payment and agreement are for per diem reimbursement.	There are no other options. A modifier is required if a substitute physician is covering for a regular physician.
3 DCs are in a group practice under one tax ID. Patients are not assigned to any one provider. One DC sees a patient that her colleague doesn't see.	Do not use a Q5 modifier for physicians in the same group. The regular physician CANNOT be treating patients at any location during a substitute physician's coverage.	Do not use a Q6 modifier for physicians in the same group. The regular physician CANNOT be treating patients at any location during a substitute physician's coverage.	Neither the Q5 nor Q6 modifier applies. Refer to the CMS 1500 Form guidelines for Box 24D regarding provider's ID.
A DC is going to leave surgery and will be out for 6 weeks. The DC contacts a local anesthesiologist (service) to replace out to a DC to set up a 90-day time agreement with a substitute physician.	Do not use a Q5 modifier if you are using a 90-day time agreement.	Append modifier Q6 in box 24D on the regular physician's 1500 Claim Form for each time service on the claim. (See Fig. 2 on next page. This indicates that a substitute physician performed the service under a 90-day time agreement.)	There are no other options. A modifier is required if a substitute physician is covering for a regular physician.
A temp for an extended absence is not recommended. A written fee-for-time compensation agreement is best practice. Do not use a Q5 modifier if an agreement is for more than 90 consecutive days.	A temp for an extended absence is not recommended. A written fee-for-time compensation agreement is best practice. Do not use a Q5 modifier if an agreement is for more than 90 consecutive days.	Append modifier Q6 for each day that falls within the 90-day limitation. DO NOT bill Q6 beyond the 90-day limitation. See the Medicare Billing Example on the next page for more information.	There are no other options. A modifier is required if a substitute physician is covering for a regular physician.

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What Could Be Wrong?

- Full spine adjusting and billing
- Missing complaints in documentation
- Overuse of 98940 for cash
- Lack or inappropriate use of S8990
- Missing extraspinal adjustments

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Physical Therapy and Modalities

Modality and Procedure Codes			
Modalities and Procedures	Total	Total by Category	Ratio by Category
97010	0	1242	0.00%
97012	1242		100.00%
97014	0		0.00%
97016	0		0.00%
97018	0	0	0.00%
97022	0		0.00%
97024	0		0.00%
97026	0		0.00%
97110	0	0	0.00%
97112	0		0.00%
97113	0		0.00%
97116	0		0.00%
97124	0	0	0.00%
97139	0		0.00%
97140	0		0.00%
97150	0		0.00%

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What to Watch For


- Overuse of passive modalities
- Ratio of passive to active
- Unusual usage compared to CMT usage
- Manual therapy or massage ratio to CMT

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### Outliers Are Audited & Made Example

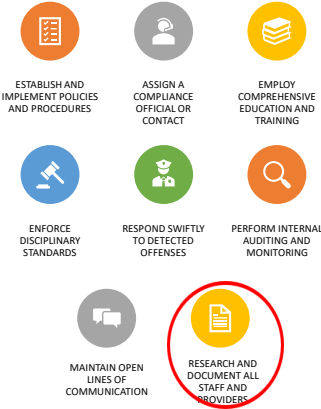
2013	2014	2015	2015	2016
Department of Health and Human Services OFFICE OF INSPECTOR GENERAL BRIEF COMMUNITY WILLIAMS, INC., EXERCISE UNUSUAL MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES	Department of Health and Human Services OFFICE OF INSPECTOR GENERAL A MICHIGAN CHIROPRACTIC EXERCISE UNUSUAL MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES	Department of Health and Human Services OFFICE OF INSPECTOR GENERAL ALLEGANY WILLIAMS CENTER EXERCISE UNUSUAL MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES	Department of Health and Human Services OFFICE OF INSPECTOR GENERAL ALLEGANY WILLIAMS CENTER EXERCISE UNUSUAL MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES	Department of Health and Human Services OFFICE OF INSPECTOR GENERAL A MICHIGAN CHIROPRACTIC EXERCISE UNUSUAL MEDICARE 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.”**

 **Compliance**


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7 Elements  
of an OIG  
Compliance  
Program  
(+1)



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### Documentation Great or Meh?

 **Documentation**

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Good Documentation  
Tells a Story

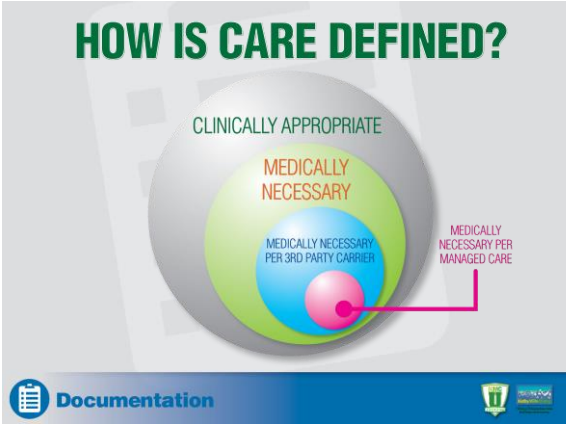
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### Know your Audience

- Another health care provider
- Your board
- A malpractice attorney
- Third party payer's medical necessity auditor

 **Documentation**

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## Heightened Awareness of Hot Spots

- Medicare patients
- Third-party patients
- Episodes of care going longer than 60 days
- Patients who haven't been seen for 30-45 days
- Returning patients

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## Medicare Documentation Guidelines

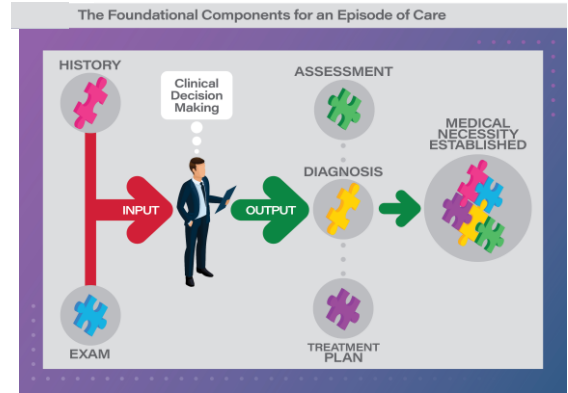
Initial Visit	Subsequent Visits
<ul style="list-style-type: none"><li>• History</li><li>• Description of Present Illness - including functional deficit(s)</li><li>• Proof of Subluxation<ul style="list-style-type: none"><li>• PART or X-ray</li></ul></li><li>• Physical Exam (PART)</li><li>• Assessment &amp; Diagnosis<ul style="list-style-type: none"><li>• 1<sup>st</sup> Subluxation</li><li>• 2<sup>nd</sup> Condition</li></ul></li><li>• Treatment Plan</li><li>• Date of initial treatment</li></ul>	<ul style="list-style-type: none"><li>• History</li><li>• Review of chief complaint</li><li>• Physical Exam (PART)</li><li>• Document daily treatment</li><li>• Progress related to treatment goals/plan (Assessment)</li></ul>

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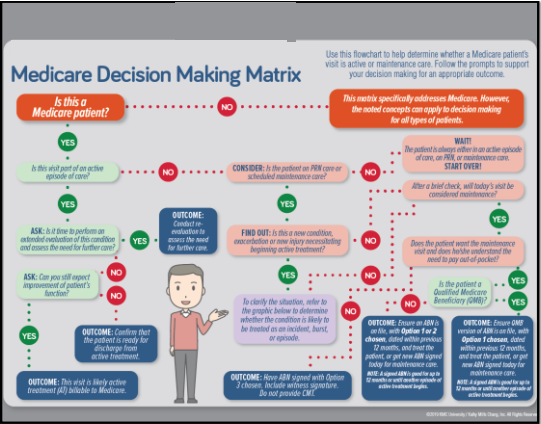
## Understand and Implement Medical Necessity Definitions

The definition of Medical Necessity, per Medicare, is: 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.

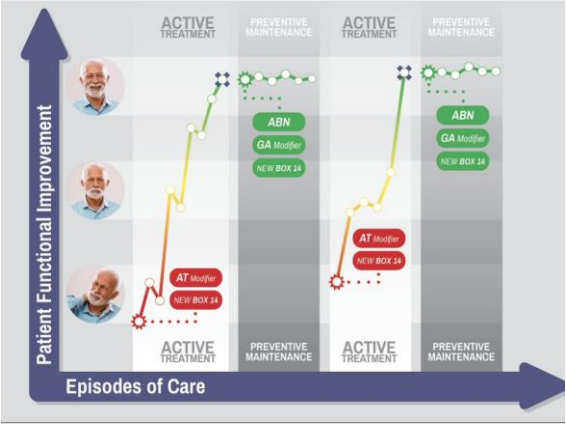
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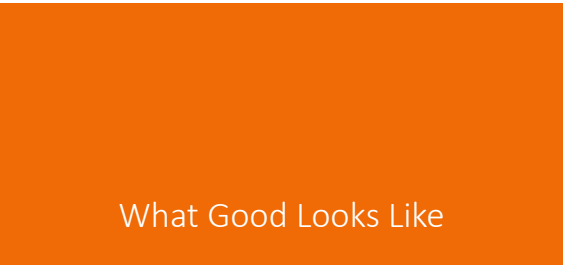
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Initial Visit	
Initial visit notes tend to be more robust than daily routine office visits or SOAP notes. An Evaluation and Management (E/M) service is documented in an initial visit and lays the groundwork for the entire course of treatment. An initial visit is any visit that kicks off a new episode of care, whether for a new or returning patient. <b>Note:</b> This can include an existing patient presenting with a new condition, an exacerbation, or a new injury.	
Medicare's Stated Requirement	What It Means
<b>A detailed patient history</b> that includes: <ul style="list-style-type: none"><li>Symptoms that caused the patient to seek treatment and when the problem started.</li><li>Description/mechanism of the current injury.</li><li>Quality, character, frequency, and location of the symptoms.</li><li>Relevant relevant family history and past health history.</li></ul>	<ul style="list-style-type: none"><li>Each initial visit, whether a new patient or new episode of active care, must include necessary history components of the E/M service, beyond simple "subjective".</li><li>Identification of specific functional abilities that are affected by the condition, including measurable deficits in Activities of Daily Living (ADLs).</li><li>With multiple complaints, outline each complaint with details as noted.</li><li>The initial visit documentation clearly forms the baseline, foundational visit for the episode of care, detailing why the patient is seeking care.</li><li>There is a clear mechanism of injury, or comments regarding when the condition started. If no clear injury has occurred, rule out accidents, slips, trips and falls and indicate when the pain started.</li><li>Update any changes in family and health history, and social history or habits on returning patients, as appropriate.</li></ul>
<b>An evaluation of the musculoskeletal</b> & nervous system determined through a physical exam.	<ul style="list-style-type: none"><li>The components of PMST should be present for all spinal regions in which there is a complaint. If using x-ray to identify the sublocation, include the findings and date of the study.</li><li>Appropriate orthopedic and neurological test performed to quantify the complaints and justify the diagnosis.</li><li>Specific segments for primary areas to be treated are clearly indicated.</li><li>Secondary compensations, or atypical findings are clearly indicated.</li><li>Include additional body systems or areas that may be affecting, or be affected by, the presenting problem.</li></ul>
<b>A diagnosis</b> (Note: the primary diagnosis for Medicare that the sublocation) that includes a stated need or that is identified by a term descriptive of sublocation.	<ul style="list-style-type: none"><li>The medical record contains written diagnoses for each condition/region to be addressed, with or without ICD-10 codes.</li><li>Diagnoses are "single" per the Medicare rules, with primary as sublocation (segmental dysfunction) and secondary as the neuromusculoskeletal diagnosis, listed for each spinal region.</li></ul>
<b>A plan for treatment</b> including recommended level of care, duration and frequency of visits, the specific functional treatment goals related to the impacted activities of daily living and objective measures to evaluate the effectiveness of the treatment.	<ul style="list-style-type: none"><li>Include the expected duration or length of treatment for this active episode of care.</li><li>Indicate the frequency of visits up to the first re-evaluation or discharge if the episode is expected last less than a month.</li><li>List short-term and long-term goals related to the functional deficits collected in the history section of the note. Ensure they can be easily measured on a valid tool/scale.</li><li>Indicate what effectiveness measures you plan to use to determine whether the treatment is working. Often, Outcome Assessment Tools (OATs) are used, and the initial score is recorded with a goal score. This is easily measured at re-evaluation intervals.</li></ul>

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Maintenance therapy is defined (per Chapter 15, Section 30.5.B. of the Medicare Benefits Policy Manual) as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition.

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**HISTORY:**

**Chief Complaint:** Reports an acute complaint in the lumbar, right sacral and right buttock regions.

- Mechanism of Injury:** Patient states she **hurt over to pick up a case of water on 2/2/22** and felt a pull in her low back.
- Frequency/Quality:** Frequent (75%) but <50% of the time discomfort described as burning, "ouch" and aching.
- Relief of Symptoms:** Currently radiating down right leg to mid-calf.
- Change in Complaint/Status:** Complaint has stayed the same since the onset and the pain scale is presently rated 6/10 (10 being most severe).
- Moderifying Factors:** Relieved by: stretching and aggressive by: changing positions, coughing and sneezing, getting in or out of car, getting out of bed, getting up from sitting and household chores.
- Previous Episodes or Care:** Patient states this happened a few years ago and she went to a chiropractor and had a month of care which fixed the problem.
- Recent Diagnostic Tests:** Not for this episode. Had a x-ray 6 months ago with her PCP which she brought with her.
- No Functional Deficits:** Patients changing positions, coughing and sneezing, getting in or out of car, getting up from bed, getting up from sitting and household chores have become difficult.

No additional concerns relayed by patient.

**Systems Review:** Medicare reports status of conditions below which may relate to complaints:

- Musculoskeletal:** Other than presenting musculoskeletal complaints: left knee pain/ history of knee replacement.
- Neurological:** Other than presenting complaints, patient denies dizziness, numbness, pins/needles, weakened muscles, progressive neurological disease, temporary loss of vision, smell or hearing, dizziness and numbness.
- Cardiovascular:** Reports high blood pressure.
- Gastrointestinal:** Reports no change in function since this episode began.

**Past, Family and Social History:**

- Past Health History:**
  - Surgery:** Left knee replacement 3/2009.
  - Medications:** Lisinopril for HBP-monitored by Dr. Jones PCP.
  - Diseases:** pneumonia 5 years ago.
  - Accidents:** single automobile accident when she was 40, no residual complaints.
- Family and Social History:**
  - Social Habits:** is a social drinker, never smoked tobacco and drinks 2 to 4 cups of coffee per day.
  - Exercise Habits:** plays golf 2 days a week. Patient states she has not been able to play this week due to her back.

- Mechanism of injury/illness is clearly indicated
- Components of History of Present Illness are well-defined
- Patient specific functional deficits included
- Relevant systems related to the chief complaint are noted and reviewed
- Clinically appropriate PFS History is noted
- Easily measured on the patient returns to pre-condition status

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**EXAMINATIONS:**

- Age/Gender/DOB:** 67, Female, born 5/19/54
- Contributions:**
  - Appearance:** average build, clean-shaven, well-dressed and well-groomed
  - Vital Signs:** Height: 5'6" Weight: 160 lbs. Pulse: 82 bpm, BP: 136/90, resting left arm in the seated position.
  - Mood and Affect:** visibly uncomfortable and concerned

**Musculoskeletal Assessment:**

- Inspection with patient in right supine:** right buttock, left buttock and lumbar
- Postural Analysis:** high left shoulder, lumbar curve to the left, high right hip and short right leg (back) deformity
- Spinal Mobility/Restrictions/End-range motion:** right C2, L3, L4, L5 and right pelvis
- Diagnosed conditions/complications/notes:** right C2, L3, L4, L5 and right pelvis
- Soft Tissue Changes:** right side of neck, lumbar, left buttock and right supine muscle

**Neurological Low Back Assessment:**

- Mental Status:** evaluation performed and the patient was observed to be alert and oriented X 3 (person place time) and cooperative
- Sensory/Discomfort:** evaluation performed bilaterally. Normal dermatomal findings at all lower spinal segments
- Deep Tendon Reflexes (normal 2+)**
  - Patellar
    - Left 1+, Right 1+
  - Achilles
    - Left 1+, Right 1+
- Lower extremity resistive isometric motor testing (normal 5/5)**
  - Right:
    - Lumbar: Left 5/5 Right 5/5
    - Quadriceps: Left 5/5 Right 5/5
    - Anterior Tibialis: Left 5/5 Right 5/5
    - Gluteus Medius: Left 5/5 Right 5/5

**Thoraco-Lumbar Range of Motion - Active**

- Flexion (normal 90°)**
  - Mildly reduced with pain noted.
- Extension (normal 30°)**
  - Severely reduced with pain noted.
- Left Lat. Flexion (normal 25°)**
  - Moderately reduced with pain noted.
- Right Lat. Flexion (normal 25°)**
  - Moderately reduced with pain noted.
- Left Rotation (normal 30°)**
  - Moderately reduced with pain noted.
- Right Rotation (normal 30°)**
  - Moderately reduced with pain noted.

**Ortho - Straight Leg Raise Test** performed bilaterally. Patient indicated 5 out of 10 (10 being most severe) pain in the right lumbar sacral at 40 degrees.

**Ortho - Kemp's Test** was performed bilaterally. Patient indicated 7 out of 10 (10 being most severe) segmental level pain at L3, L4, L5, sacrum and right pelvis with radiation.

**Ortho - Heel-to-Toe Test** performed. Patient indicated no pain bilaterally.

**Ortho - Heel-to-Toe Test** performed. Patient indicated no pain bilaterally.

**Referred lumbar <exp today** provided on disc by patient. These were taken of her low back 6 months ago by her PCP. **There is noted degenerative disc disease at L3, L4, L4/5, and L5/S1.**

- Chiropractic appropriate examination conducted to quantify complaints and extent of differential diagnosis
- Medicare RPT requirements met
- Asymptomatic spinal restrictions and findings are also noted

- Medicare RPT requirements met
- Asymptomatic spinal restrictions and findings are also noted

- Medicare RPT requirements met
- Asymptomatic spinal restrictions and findings are also noted

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**ASSESSMENT:**

I have diagnosed Minnie with an acute, uncomplicated lower back condition with low risk of morbidity with the recommended treatment. She is in fair health and is expected to make fair progress and recover with some possible residuals. **See in order and has disc de-** **generation in the lumbar spine.** These complicating factors may affect her recovery time. Based on her history and examination, it is reasonable to believe that her recovery may take a bit longer than an average patient with no complicating factors. There appear to be no contraindications to gentle, conservative chiropractic treatment at this time.

**DIAGNOSIS:**

Upon consideration of the information available I have diagnosed Minnie with: (M99.03) Seg and Somatic dysf of lumbar reg. (M54.48) Lumbago w/ sciatica, RT side; (M99.05) Seg and Somatic dysf of pelvic reg. (M53.37) Other intervertebral disc degeneration, lumbosacral region, (M62.830) Muscle spasm of back.

**Compensatory Diagnosis found on exam: (M99.01) Seg and somatic dysf of cervical reg.**

- This language in the assessment points to the doctor's decision making when coding
- Prognostic factors noted
- Active diagnoses are listed in descending order of severity and according to Medicare coupling requirements
- Findings are consistent with this diagnosis, even if it will be deemed a compensatory area and not eligible for billing

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**TREATMENT PLAN:**

Minnie's treatment plan for this episode **begins 2/5/2021 and is projected to be completed by 2/22/2021.**

- Short Term Tx Goal:** to get in and out of the car, out of bed and rise from sitting without pilling pain within 30 days, unless improvement warrants discharge sooner.
- Long Term Goal:** attain pre-episode status which is playing golf 3 days a week without pain and to have no limitations when rising out of bed or from a seated position.
- Treatment Frequency:** We start an initial therapeutic trial of care with 6 to 12 visits over a 2 to 4-week period. A determination of the necessity for additional treatment will be based on the response to the initial trial of care and the likelihood that additional gains can be achieved.
- Chiropractic Manipulative Treatment (CMT):** Diversified, Drop Table and Activator to the lumbar and thoracic regions; lumbar and pelvic; Activator to the **upper cervical spine and sacral region.**
- Supportive Therapy:** To optimize the treatment effectiveness, the following supportive therapies are ordered:
  - Traction:** Mechanical Flexion/Extension without CMT to be performed to bilateral lower lumbar, upper lumbar and sacral to increase joint mobility and to increase disc height & hydration during relief phase treatment for 4 minutes at a frequency of 3 visits per week for next 4 weeks.
  - Ultrasound:** ultrasound with contact medium to be performed to right lower lumbar and buttock regions to decrease spasm during relief phase treatment for 8 minutes at a frequency of 3 visits per week for next 2 weeks.
- Tx Effectiveness:** to be evaluated by analyzing objective and subjective findings, along with the results of the **Time Back Disability Questionnaire (Disability Scale: 0-20% = minimal disability; 21-40% = moderate disability; 41-60% = severe disability; 61% = very severe disability).**
  - Initial Score: 55**
  - Goal Score: 20% or better**

- Estimated duration of total treatment plan itemized
- Short and long term goals are specific, measurable, attainable, relevant and time bound
- Primary, medically necessary spinal regions noted
- Compensatory, clinically appropriate spinal region noted
- Use of the GDS data for treatment effectiveness is easily measured at evaluations
- The mobility, location, frequency, and duration, along with rationale are noted
- Treatment rendered is separately noted and coded

**TODAY'S TREATMENT:**

- Primary Treatment (1-2 regions):** Diversified, Drop Table and Activator - Chiropractic Manipulative Treatment (CMT) to the right pelvis and right L5 spinal level.
- Compensatory adjustment(s) at level(s):** right C2-Activator
- Supportive Therapy** to optimize treatment effectiveness the following therapy(ies) were performed today:
  - Ultrasound with contact medium performed to right lumbar and right buttock region(s) for 8 minutes at a setting of continuous 100% and at 16 W/cm2.

Examination and treatment rendered without incident.

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## The Routine Office Visit (ROV) Defined

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### Discern Initial from Routine Visits

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Last Step: Doctor Fixing

- Clarify and execute your plan
- Goals are associated with the plan
- Medical necessity is clear
- Code the correct treatment that you chose



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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<sup>st</sup> Subluxation
    - 2<sup>nd</sup> 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)

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What Good Looks Like



75

Active Treatment Routine Office Visit (ROV) Subjective

**S**

**Daily Encounter:** treatment for acute/active care on **Visit #5** of a projected 20 visits

- **Chief Complaint:** Reports drowsy, aching, stiffness type discomfort in the **lower back** of the neck; this complaint has **improved since the last visit**. The patient reported, **"I was able to sleep a few nights" (I removed my pillow and rolled up a towel and that helped)**.
- **Pain Scale:** 4/10 reported using Verbal or Visual Analog Scale
- **Current Functional Deficit(s):** Kathleen stated that **standing is just difficult but she can now walk upstairs**.

-----

- **Complaint #2:** Reports dull aching type discomfort in the **left and right side of the lower back** and the **left and right shoulders**.
- **Pain Scale:** 3/10 reported using Verbal or Visual Analog Scale
- **ADL Change:** **lifting has improved slightly; she can sit in a comfortable chair for long periods without pain**.

- Visit number is clearly indicated
- Location and spinal region is clear
- Changes in function since last visit are clear
- Patient specific functional notes included

- Visit number is important during an episode
- If more than one complaint, list all detail
- Keep the focus on function as much as possible

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Preventive Maintenance Visit Subjective

**S**

**Subjective:**

**Daily Encounter:**

- **Subjective/Patient Assessment:** Preventative Maintenance Encounter. Theresa was **asymptomatic** today but reported intermittent **right lower back stiffness** with prolonged sitting due to her job. **Pain scale reported as 1/10**. Theresa currently has **no major functional deficits** or restrictions in her activities of daily living or playing softball on the weekends. She returns today to be examined and, if indicated, adjusted for subluxations.

- These minimal concerns and no functional loss indicate clinical appropriateness but lack of medical necessity.

- Record the patient's subjective reason for the visit
- It's OK to only discuss pain, but nod to the functional deficits if they exist
- Visit Number is less important in this note

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Wellness Visit Subjective

**S**

**Daily Encounter:**

- **Wellness Encounter:** Jenny was **asymptomatic** today and returned to be examined and, if indicated, adjusted for subluxations. Jenny currently has **no functional deficits or restrictions** in her activities of daily living.

- Reason for the visit is clearly established
- Statement to indicate no complaint or asymptomatic as reported by patient
- Brief notation of the patient's lack of functional deficits is noted

- Note that it's a wellness visit, per your definition
- It's OK to only discuss pain if it exists, and to note that the patient is asymptomatic
- Visit Number is less important in this note

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Active Treatment Routine Office Visit (ROV) Objective

0

**Objective:**

**Daily Objective Findings:**

- Spinal Restrictions/Subluxations: **left C3, C4, right C5, L3, L4, L5, right sacrum and right pelvis**
- **Compensatory/Incidental Subluxations: T5-T6**
- Pain/Tenderness: Cervical, cervico-thoracic, upper thoracic, lower lumbar and lumbosacral
- Postural Analysis: **slight left leg/groin deficiency**, head rotation left, high right shoulder, thoracic hyperkyphosis and high left hip
- Muscle Spasms: Hypertonic **posterior cervical muscles, left trapezius, upper thoracic, right posterior trapezius and thoracic, lumbar and left biceps**
- ROM Concerns: **cervical extension, lumbar right rotation and lumbar right lateral bend**, moderately reduced with pain

- Objective findings clear for all spinal regions being treated
- Incidental subluxations not related to the complaints are noted
- PART is clearly indicated for all regions being treated

- Parts of PART can be a simple basis for objective
- Separate incidental subluxations from active
- Include what's necessary to justify and validate today's treatment—muscle related if performing muscle work

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Preventive Maintenance Visit Objective

0

**Objective:**

**Daily Objective Findings:**

- Spinal Restrictions/Subluxations: **R1, L1/T12, R1 L4 Sacrum, R1 ilium**
- Postural Analysis: right short leg, mild anterior head carriage, right low shoulder
- Tissue Tone Changes: **mild tightness on the right side of the neck, moderate right knee and tenderness in the R1 lumbar region, mild to moderate hypertonicity and mild to moderate tenderness of R1 Pelvis/Sacro notch and R1 Gluteus Medius**

- Objective findings clear for all spinal regions being treated

- There can be objective findings and it's still considered preventive maintenance
- Record findings that align with your technique
- Spinal restrictions listed warrant adjustment of those segments

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Wellness Visit Objective

0

**Daily Objective Findings:**

- Spinal Restrictions/Subluxations: **C2, C5, L4, and right ilium**
- Postural Analysis: right short leg, mild anterior head carriage
- Tissue Tone Changes: **mild tightness on the right side of the neck and lumbar region**

- Objective findings clear for all spinal regions being treated

- There can be objective findings and still considered wellness treatment
- Record findings that align with your technique
- Spinal restrictions listed warrant adjustment of those segments
- The intent of the visit and subjective documentation helps clarify

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Active Treatment Routine Office Visit (ROV) Assessment

A

**Assessment:**

Is the **daily phase of treatment** progress expected as plan progresses **with supporting of** **after first adjustment** is within normal limits and should subside as treatment continues.

- Daily assessment is personalized and patient specific

- Early visit example
- Doctor's assessment
- Personalized
- How and Why are clear

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Preventive Maintenance Visit Assessment

A

**Assessment:**

- Current Status: **Preventive Maintenance** care for subluxation correction to maintain neuro-spiral integrity and prevent deterioration of the functional spinal motion units. Patient is fully functional and without pain or symptoms in all their activities. She will further benefit from an **additional spinal evaluation within the week** given some of today's findings.

**Diagnosis:** (M99.02) Thoracic Subluxation, (M99.03) lumbar subluxation, (M99.04) Sacral Subluxation (M99.05) pelvic subluxation

- Minimal Assessment due to the nature of the patient presentation
- Basic diagnosis is expected for Preventive Maintenance visits and patient receipt

- Record the current status and elaborate if necessary.
- Maintenance can look different from visit to visit, so detail here is helpful
- Include the diagnosis here, as it may be the only place it appears

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Wellness Visit Assessment

A

**Daily Assessment:**

- Current Status: **Wellness care** for subluxation correction to maintain and improve neuro-spiral integrity, overall health, and general wellbeing.
- **Diagnosis:** (M99.01) cervical subluxation, (M99.03) lumbar subluxation, (M99.05) pelvic subluxation

- Minimal assessment due to the nature of the patient presentation
- Basic diagnosis is expected for wellness visits and patient receipt

- Note that it's a wellness visit, per your definition
- Asymptomatic assessment is perfectly fine given the lack of findings beyond subluxation
- Consider using diagnosis in this section since it may be the only place it shows up

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Active Treatment Routine Office Visit (ROV) Plan

P

Plan:

Today's Treatment:

- Primary Treatment: **Diversified, Chiropractic Manipulative Treatment (CMT)** to the left C3, C4, right C5, L3, L4, right L5, right sacrum and right pelvis spinal levels.
- Compensatory adjustment(s) at level(s): T5, T6

Supportive Therapy:

- Hot Packs** not moist pack applied to posterior cervical (neck) and lumbar regions for **10 minutes**
- Ultrasound with contact medium** applied to posterior cervical (neck) region for **10 minutes** at a setting of continuous 100% and at 1.0 W/cm2
- Low volt EMS, unattended** applied to lumbar, left and right sacroiliac regions for **10 minutes**

Advised:

- 1x Effect: Treatment rendered without incident
- Next Visit: continue with treatment plan as scheduled

- Chiropractic technique clearly indicated
- Specific segments adjusted are noted
- Compensatory segments addressed are noted separately
- Auxiliary services are clearly indicated, with location and details
- Time is documented for all therapies

- Segments must be listed
- Specifics on therapies
- Individual and total time must be recorded

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Preventive Maintenance Visit Plan

P

Plan:

Today's Treatment:

- Primary Treatment: **Diversified, Drop Table** - Chiropractic Manipulative Treatment (CMT) to the **L1, T11, T12, R1, L4, R1 Sacrum, R1 Ilium** spinal levels.

Home Care: hip abductor stretching previously given.

Advised:

- 1x Effect: Treatment rendered without incident
- Next Visit: within 1 week and then expected to resume monthly treatment

- Chiropractic technique clearly indicated
- Specific segments adjusted are noted
- Basic information to demonstrate patient management

- Indicate all treatment and especially spinal segments
- Include technique
- Advised and next steps are important here

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Wellness Visit Plan

P

Today's Treatment:

Primary Treatment: **Diversified, Drop Table** - Chiropractic Manipulative Treatment (CMT) to the **right C2, right C4, L4 and right lumbar** spinal levels.

Advised:

- 1x Effect: Treatment rendered without incident
- Next Visit: continue with monthly treatment plan

- Chiropractic technique clearly indicated
- Specific segments adjusted are noted
- Basic information to demonstrate patient management

- Basic information is shared here since it's asymptomatic care
- List the segments and technique-at least minimum standards for your board
- Indicate next steps

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Let's Roll Up Our Sleeves and Dig In

88

Initial Date of Service: 6/9/23

What is this visit related to?

☒ Home

☐ Motor Vehicle Accident ☐ Worker Related Injury

What type of complaint?

☒ An acute ☒ A chronic ☐ A recurring ☐ A sub-acute

Where is chief complaint?

**Neck pain**

Is complaint getting better, worse or staying the same?

☐ Improved ☐ Relief that lasted awhile ☒ Stayed the same ☐ Worsened

What is the VAS? Rate your pain on a scale of 1-10 (10 being worst)

☐ 1/10 ☐ 2/10 ☒ 3/10 ☐ 4/10 ☐ 5/10 ☐ 6/10 ☐ 7/10 ☐ 8/10 ☐ 9/10 ☐ 10/10

What is symptom relieved by?

☐ OTHER ☒ chiropractic adjustment ☒ cold packs ☐ exercise

☒ heat packs ☒ massage ☐ nothing ☐ over the counter medication

☒ physical therapy ☒ prescription medication ☐ in direct situation ☒ sleep

☒ stretching ☐ work ☐ rest

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How did this injury or condition occur?

What was date of onset for this condition?

**6/9/23**

What condition caused by a FALL, INJURY or ACCIDENT?

☒ Denies any connection to injury or accident ☐ Perpetrating event was a fall

What is frequency of pain?

☒ OTHER ☐ Constant (100% of the time)

☒ Frequent (75% but < 50% of the time) ☐ Occasional (< 50% but > 25% of the time)

What is quality of discomfort?

☒ OTHER ☒ aching ☒ burning ☐ sharp

☒ dull ☐ heavy ☐ numbness ☐ tingling

☒ itchy ☐ prickly ☐ stinging ☐ throbbing

If the discomfort radiates, where does it travel to? Otherwise, choose non-radiating

☐ non-radiating ☐ radiating to front of left chest ☐ radiating to front of right chest

☐ radiating to front of left abdomen/ribs ☐ radiating to front of right abdomen/ribs

☐ radiating to front of left upper arm ☐ radiating to front of right upper arm

☐ radiating to front of left lower arm ☐ radiating to front of right lower arm

☐ radiating to front of left hand ☐ radiating to front of right hand

☐ radiating to front of left foot ☐ radiating to front of right foot

☐ radiating to front of left leg ☐ radiating to front of right leg

☐ radiating to front of left thigh ☐ radiating to front of right thigh

☐ radiating to front of left calf ☐ radiating to front of right calf

☐ radiating to front of left ankle ☐ radiating to front of right ankle

☐ radiating to front of left toe ☐ radiating to front of right toe

☐ radiating to front of left heel ☐ radiating to front of right heel

☐ radiating to front of left arch ☐ radiating to front of right arch

☐ radiating to front of left ball ☐ radiating to front of right ball

☐ radiating to front of left sole ☐ radiating to front of right sole

☐ radiating to front of left heel ☐ radiating to front of right heel

☐ radiating to front of left arch ☐ radiating to front of right arch

☐ radiating to front of left ball ☐ radiating to front of right ball

☐ radiating to front of left sole ☐ radiating to front of right sole

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What aggravates the symptoms?	<ul style="list-style-type: none"> <li>OTHER</li> <li>none</li> <li>waking</li> <li>changing positions</li> <li>standing</li> <li>walking</li> <li>getting up from lying bed</li> <li>pushing</li> <li>resting</li> <li>drinking</li> <li>yard work</li> </ul>	<ul style="list-style-type: none"> <li>unknown when</li> <li>going to the bathroom</li> <li>coming out of bed</li> <li>only mild or not even</li> <li>getting up in the end of car</li> <li>pushing against</li> <li>drinking cold</li> <li>walking</li> <li>standing</li> <li>drinking</li> <li>exercising</li> </ul>	<ul style="list-style-type: none"> <li>almost any movement</li> <li>laying</li> <li>concentrating</li> <li>standing</li> <li>getting out of bed</li> <li>drinking</li> <li>pushing</li> <li>negative emotions</li> <li>drinking</li> <li>working on the telephone</li> <li>working</li> </ul>
Any past episodes of this complaint?	<ul style="list-style-type: none"> <li>OTHER</li> <li>no</li> <li>yes</li> </ul>	<ul style="list-style-type: none"> <li>no</li> <li>yes</li> </ul>	<ul style="list-style-type: none"> <li>no</li> <li>yes</li> </ul>
Has patient experienced any past care for this complaint?	<ul style="list-style-type: none"> <li>OTHER</li> <li>Chiropractic</li> <li>hypnosis</li> <li>Herbal supplements</li> <li>Chiropractic medicine</li> <li>physical therapy</li> <li>any</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic</li> <li>Chiropractic</li> <li>injection therapy</li> <li>herbal supplements</li> <li>use the counter medications</li> <li>psychotherapy</li> </ul>	<ul style="list-style-type: none"> <li>Acupuncture</li> <li>herbopathic medicine</li> <li>medical care</li> <li>herbal supplements</li> <li>prescribed medications</li> <li>Pain</li> </ul>
Have any recent diagnostic images or tests been performed?	<ul style="list-style-type: none"> <li>OTHER</li> <li>no</li> <li>yes</li> </ul>	<ul style="list-style-type: none"> <li>no</li> <li>yes</li> </ul>	<ul style="list-style-type: none"> <li>No</li> </ul>
What activity of daily living most affected?	<ul style="list-style-type: none"> <li>OTHER</li> <li>nonworking</li> <li>standing</li> <li>walking</li> </ul>	<ul style="list-style-type: none"> <li>none</li> <li>standing</li> <li>walking</li> <li>breathing</li> <li>standing</li> <li>breathing</li> <li>standing</li> <li>breathing</li> <li>standing</li> </ul>	<ul style="list-style-type: none"> <li>waking</li> <li>personal care (washing, dressing, etc.)</li> <li>standing</li> <li>walking</li> </ul>

**What does patient have difficulty performing due to this specific injury?**

<input type="checkbox"/> OTHER	<input type="checkbox"/> bending over	<input checked="" type="checkbox"/> caring for family	<input type="checkbox"/> climbing stairs
<input type="checkbox"/> concentrating	<input type="checkbox"/> dressing self	<input checked="" type="checkbox"/> driving car	<input type="checkbox"/> exercising
<input type="checkbox"/> getting in/out of car	<input type="checkbox"/> getting to sleep	<input type="checkbox"/> grocery shopping	<input checked="" type="checkbox"/> performing household chores
<input checked="" type="checkbox"/> lifting objects	<input checked="" type="checkbox"/> looking over shoulder	<input type="checkbox"/> making love	<input type="checkbox"/> lying down
<input type="checkbox"/> reaching overhead	<input checked="" type="checkbox"/> rising out of chair or bed	<input type="checkbox"/> showering or bathing	<input type="checkbox"/> sitting
<input type="checkbox"/> standing	<input type="checkbox"/> staying asleep	<input checked="" type="checkbox"/> using a computer	<input checked="" type="checkbox"/> walking
<input type="checkbox"/> participating in yard work			

**Is there a 2nd complaint?**

☒ Yes ☐ No

**What type of complaint?**

<input checked="" type="checkbox"/> an acute	<input type="checkbox"/> a chronic	<input type="checkbox"/> a recurring	<input type="checkbox"/> a sub-acute
--	------------------------------------	--------------------------------------	--------------------------------------

[illegible][illegible]

What is a cell component?	cell wall
<p>Four potential parts of a cell:</p> <ul style="list-style-type: none"> <li>cell wall</li> <li>cell membrane</li> <li>cytoplasm</li> <li>nucleus</li> </ul>	<p>What are the four main parts of a cell?</p> <ul style="list-style-type: none"> <li>cell wall</li> <li>cell membrane</li> <li>cytoplasm</li> <li>nucleus</li> </ul>
<p>What are the functions of the following? Microvilli and cilia?</p> <ul style="list-style-type: none"> <li>Microvilli: increase surface area for absorption</li> <li>Cilia: move substances along the surface of the cell</li> </ul>	<p>What are the functions of the following? Microvilli and cilia?</p> <ul style="list-style-type: none"> <li>Microvilli: increase surface area for absorption</li> <li>Cilia: move substances along the surface of the cell</li> </ul>
<p>What are the functions of the following? Centrioles and lysosomes?</p> <ul style="list-style-type: none"> <li>Centrioles: form the spindle fibers during cell division</li> <li>Lysosomes: break down waste materials and cellular debris</li> </ul>	<p>What are the functions of the following? Centrioles and lysosomes?</p> <ul style="list-style-type: none"> <li>Centrioles: form the spindle fibers during cell division</li> <li>Lysosomes: break down waste materials and cellular debris</li> </ul>
<p>What are the functions of the following? Mitochondria and Golgi apparatus?</p> <ul style="list-style-type: none"> <li>Mitochondria: produce energy for the cell</li> <li>Golgi apparatus: transport and store materials</li> </ul>	<p>What are the functions of the following? Mitochondria and Golgi apparatus?</p> <ul style="list-style-type: none"> <li>Mitochondria: produce energy for the cell</li> <li>Golgi apparatus: transport and store materials</li> </ul>
<p>What are the functions of the following? Peroxisomes and vacuoles?</p> <ul style="list-style-type: none"> <li>Peroxisomes: break down fatty acids and detoxify the cell</li> <li>Vacuoles: store water and other substances</li> </ul>	<p>What are the functions of the following? Peroxisomes and vacuoles?</p> <ul style="list-style-type: none"> <li>Peroxisomes: break down fatty acids and detoxify the cell</li> <li>Vacuoles: store water and other substances</li> </ul>
<p>What are the functions of the following? Smooth endoplasmic reticulum and rough endoplasmic reticulum?</p> <ul style="list-style-type: none"> <li>Smooth ER: synthesize lipids and detoxify drugs</li> <li>Rough ER: synthesize proteins</li> </ul>	<p>What are the functions of the following? Smooth endoplasmic reticulum and rough endoplasmic reticulum?</p> <ul style="list-style-type: none"> <li>Smooth ER: synthesize lipids and detoxify drugs</li> <li>Rough ER: synthesize proteins</li> </ul>

[illegible]





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**Daily Objective Findings:**

- **Spinal Restriction(s):** Subluxation(s): C7, C6, C5, T1, T2, right L4, L5, sacrum, right pelvis and left pelvis
  - **Pain/Tenderness:** mid to lower cervical, cervico-thoracic, upper thoracic, mid-thoracic and lumbo-sacral
  - **Postural Analysis:** short left leg (pelvic deficiency), head forward flexed and thoracic hyperkyphosis
  - **Muscle Spasm(s):** left side of neck, right side of neck, posterior cervical (neck), left trapezius, right posterior trapezius, upper thoracic, left anterior trapezius and right anterior trapezius tissue tone
  - **ROM Concern(s):** cervical extension, cervical left rotation, cervical right rotation, cervical left lateral flexion, cervical right lateral flexion, lumbar extension, lumbar left rotation, lumbar right rotation, lumbar left lateral flexion and lumbar right lateral flexion was recorded as moderately reduced without pain noted.

**Assessment:**

██████ is of fair health and is expected to make fair progress and recovery with some residuals. She has pre-existing pathology as complicating factor(s) and Cervical fusion C4-C7 as contraindications to chiropractic treatment. Based on her history and examination, it is reasonable to believe that her recovery may take longer than an average patient with an uncomplicated case.

**DIAGNOSIS:**

Upon consideration of the information available I have diagnosed ██████ with: (M59.23) Other cervical disc displacement, cervicothoracic region, (M59.01) Seg and somatic dysf of cervical reg, (M62.830) Muscle spasm of back, (M99.02) Seg and somatic dysf of thoracic reg, (M99.03) Seg and somatic dysf of lumbar reg, (M99.04) Seg and somatic dysf of sacral reg, (M99.05) Seg and somatic dysf of pelvic reg, (M99.06) Seg and somatic dysf of lower extremity, (M99.07) Seg and somatic dysf of upper extremity

**Plan:**

**ROF-Consent:** Before treatment was rendered, a Report of Findings was presented. I reviewed the condition as I see it with ██████ the recommended treatment/schedule, options, relative risks, and financial obligations. All questions were addressed and ██████ expressed an understanding. At this time, an Informed Consent was signed and treatment begins today.

**TREATMENT PLAN:**

██████ treatment plan for this episode began on 6/14/2023 and is projected to be completed by 8/9/2023.

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**Primary Treatment:**

- **Chiropractic Adjustment:** Diversified - Chiropractic Manipulative Treatment (CMT) (approx: 12 to 18 visits) to the cervical spinal region and lumbar spinal region at a frequency and duration of 1-2 x a week

**- Today's Treatment:**

- **Primary Treatment:** Diversified- Chiropractic Manipulative Treatment (CMT) to the C7, C6, C5, T1, T2, right L4, L5, sacrum, right pelvis and left pelvis spinal level(s).

**- Advised**

- **Tx Effect:** Treatment rendered without incident and responding as expected.
- **Next Visit:** continue with treatment plan as scheduled 2 x a week for adj and DN

Request images from star imaging in Nile

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Read the question and fill in the appropriate bubble. If the answer is No, fill in the only bubble option available under one of the three columns on the right.	YES or N/A	IMPROVEMENT OPPORTUNITY	MEDICAL NECESSITY	COOR/POLICY
<b>General Considerations</b>				
1. Is the provider's signature correctly added to the note? If yes, is it contemporaneous? If no, is there an attestation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Is the documentation legible enough to meet guidelines?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Is the name of Beneficiary and date of service on all documentation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>History</b>				
4. Does the history of the Chief Complaint contain enough information to establish a cause for the visit (i.e. mechanism of injury)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Does history contain enough of a description of the Chief and Additional Complaints (i.e. OPQRST) to necessitate an examination of the area(s)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Does history address the patient's past history with this problem, previous and/or similar episodes, treatments, and treatment outcomes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Does the history include measurable functional restrictions and/or functional deficits for each complaint?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Does history include relevant ROS and PFSH necessary to rule in or out Complicating Factors and Red Flags to CMT or supportive therapies?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Was an independent historian required or utilized for the intake of the history? And if so, was that documented?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Does the history meet all the requirements as noted in the Part 6 Local Coverage Article (LCA) for the doctor's location?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Examination	YES or N/A	IMPROVEMENT OPPORTUNITY	MEDICAL NECESSITY	COOR/POLICY
1. Does the examination clinically correlate with the patient's documented complaints?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Are Primary Findings that are medically necessary separated from clinically appropriate Compensatory Findings in the objective section?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Were outcome assessment tool(s) used with this episode of care, and if yes, were they properly scored and admitted into the patient's record?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. If there are outside records, testing results (radiology, lab, neurology, etc.), images, or scans included with the initial visit information, did the treating Chiropractor sign and date each report to acknowledge review? If yes, is there a summary present in the notes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Were there X-rays ordered to be taken internally or by referral? If so, was the rationale, analgesic X-rayed, and radiology findings documented?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Is the Subluxation for each area treated demonstrated with either (A) 2 or more elements from PMPT (must be A or R), or (B) Radiology: the DC's note includes date of imaging and level of Subluxation (note: be aware of acceptable timelines for X-rays depending on the chronology and/or permanency of patient's condition; MRI and CT scans are acceptable).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Assessment</b>				
7. Is there an Assessment present that is not simply the Diagnosis?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. If there are outside test results (radiology, lab, neurology, etc.), images, or scans, are the results discussed in the initial visit assessment as they pertain to Medical Decision Making (MDM)? MDM was used to select the CMT code?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Are patient reporting, examination findings, Prognosis/Complicating Factors, Risk Factors, test results, and any unusual circumstances documented to substantiate care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Is the level of Medical Decision Making (MDM) clearly documented if MDM was used to select the CMT code?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Does the Assessment address the existence of Red Flags (Indications / Contraindications) in the planned treatment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Does the documentation confirm the symptoms bear a direct relationship to the Subluxation level causing the patient to seek treatment for each area of complaint?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Audit Tool - Initial Visit - Page 2	YES or N/A	IMPROVEMENT OPPORTUNITY	MEDICAL NECESSITY	COOR/POLICY
<b>Diagnosis (DC)</b>				
13. Do all areas of complaint that are going to be treated have a diagnosis?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Is the diagnosis for each complaint supported by the documented history and findings in the examination? For diagnosis codes requiring advanced testing, are the test results included in documentation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. If additional work-up or referral is ordered, is rationale and an acceptable preliminary or working diagnosis documented?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Are any non-musculoskeletal diagnosis codes reported on the 1500 claim form? If so, are they documented in the record?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Are the diagnosis listed the highest degree of severity and/or specificity for the condition(s) reported and reviewed in history and examination?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Are the Musculoskeletal diagnosis codes reported with the Primary Subluxation code first and the Neuromusculoskeletal condition code as the Secondary Diagnosis code for each region being held for active treatment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Treatment Plan</b>				
19. Does the Treatment Plan include the start date and estimated end date, visit frequency, and duration, and a re-evaluation to be performed in about 30 days?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Does the Initial Treatment Plan contain specific, measurable, and functional short-term and long-term treatment goals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Does the Initial Treatment Plan contain objective measures that can be used to evaluate treatment effectiveness from initial visit to each re-evaluation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. Is the recommended CMT applied with rationale, technique, and regions to be adjusted?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. Are the recommended therapies/modalities ordered, supplied with rationale for their use, location, and settings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. If more invasive, additional diagnostics, or DME are ordered, is there justification (radiology, nerve studies, US, etc.) and is there justification from history/examination/testing or records, diagnosis to support the order?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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**E/M Coding/Billing**

36. Does the CPT level billed match the Documentation? If MDM was used, is the level billed supported by the documentation? If time was used, is patient facing, non patient facing, and total time clearly noted?

37. If Medicare, was modifier GT appended to S50XX, and the Initial GT date included on the CMS-1500 line 14?

38. Was a Voluntary ABN, or Special Notice, used at the beginning of the episode, and if so, was it used correctly?

**If no other services were rendered, you are finished with this portion of the audit.**

**Today's Treatment**

39. If CMT is performed, does it name the technique utilized to each area treated?

40. If CMT is performed, are Primary and Compensatory adjustments separated? Do the Primary segments adjusted match the restrictions in the examination, and match the level of CMT billed?

41. If Supportive Therapies were utilized, are all their required parameters (area, time, etc.) included to support their use, and do they match the Treatment Plan?

**Coding/Billing**

42. Does the CPT claim information of diagnosis, CPT code level, modifier use, match the documentation, and are there any potential CPT edit conflicts with other services provided today?

43. If Supportive Therapies were utilized, are the service codes billed in line with the initial treatment plan, billed coding rules, if applicable, and assigned proper modifiers?

44. If Durable Medical Equipment (DME) or other supplies were dispensed to the patient and billed to a third party, does the documentation match the code selected?

45. If Medicare is an RT appended to 80907?

46. If an official ABN was used, was it used correctly? (if not signed, option not chosen, no CMT present)

47. Does CPT coding on the claim form contain and match the chart's Primary Subdiagnosis diagnosis and a supportive NMS secondary condition for each spinal region listed?

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**15 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)**

**16 OTHER DATE**

**17 NAME OF REFERRING PROVIDER OR OTHER SOURCE**

**18 DATE OF LAST VISIT TO WORK IN CURRENT OCCUPATION**

**19 ADDITIONAL CLARIFY INFORMATION (Designated by NUGO)**

**20 DISCHARGE OR NATURE OF ILLNESS OR INJURY**

**21 DATE OF SERVICE**

**22 PROCEDURE, SERVICE, or SUPPLY**

**23 CHARGES**

**24 PAYOR**

**25 PAYOR'S ACCOUNT NO.**

**26 TOTAL CHARGE**

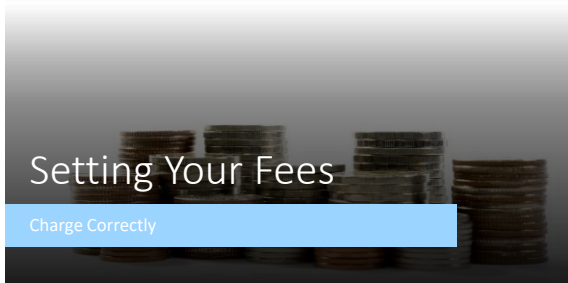
**27 AMOUNT PAID**

**28 PATIENT'S SHARE**

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You MUST Begin By  
Charging Correct Fees!

- A famous person once said, "Your fee is your fee is your fee!"
- From there, who qualifies for which discounts?
- A clear understanding of fees allows for appropriate collections

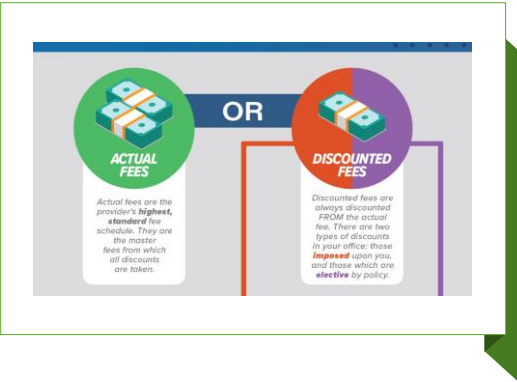
112



113



114



115



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117

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## Compliant Time of Service Discounts



According to federal guidance, a reasonable time-of-service discount is 5-15%

Discount is based on bookkeeping  
May or may not be defined  
Often not defensible or unreasonable  
• May not be permissible on Federally insured patients

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- An Established Sliding Fee Schedule
- Qualify and Verify Hardship
- Should be Requested
- Policy in Place

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Clear & Defined Terms

**Financial Hardship and Indigence Policy and Agreement**

Understand that we are currently and potentially responsible for all professional charges, regardless of our financial situation. We have the ability to pay for our care and we are responsible for the above financial hardship and indigence policy and agreement. We have the ability to pay for our care and we are responsible for the above financial hardship and indigence policy and agreement.

Family Size	1-200%	2-300%	3-400%	4-500%	5-600%	6-700%	7-800%	8-900%	9-1000%
1	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000
2	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000
3	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000
4	\$25,000	\$25,000	\$25,000	\$25,000	\$25,000	\$25,000	\$25,000	\$25,000	\$25,000
5	\$30,000	\$30,000	\$30,000	\$30,000	\$30,000	\$30,000	\$30,000	\$30,000	\$30,000
6	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000	\$35,000
7	\$40,000	\$40,000	\$40,000	\$40,000	\$40,000	\$40,000	\$40,000	\$40,000	\$40,000
8	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000
9	\$50,000	\$50,000	\$50,000	\$50,000	\$50,000	\$50,000	\$50,000	\$50,000	\$50,000
10	\$55,000	\$55,000	\$55,000	\$55,000	\$55,000	\$55,000	\$55,000	\$55,000	\$55,000

**John Doe Chiropractic Clinic** 1234 Any Street, Anytown, XX 12345  
Phone (123) 123-4567 / Fax (123) 123-4567

Patients who qualify for indigence consideration based on the poverty guidelines, and who have proven their inability to pay as noted below, will receive discounts as follows:

Percentage discount from actual fee, deductible, copay, or flat fee	100% of poverty or lower	101-123% of poverty	124-150% of poverty	151-175% of poverty	176-200% of poverty	201-250% of poverty
\$10 Flat Fee	Excludes: Does not apply to complex medical equipment and services.	Excludes: Does not apply to complex medical equipment and services.	Excludes: Does not apply to complex medical equipment and services.	Excludes: Does not apply to complex medical equipment and services.	Excludes: Does not apply to complex medical equipment and services.	Excludes: Does not apply to complex medical equipment and services.

Patient name \_\_\_\_\_ Patient signature \_\_\_\_\_ Date signed \_\_\_\_\_

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Hardship Internal Office Policy & Procedure

(Insert Practice Identifying Information)

Sample Policy for:

**Hardship Fees for Qualifying Patients**

It is the policy of this office to **offer (not to offer)** hardship discounts to qualifying patients. The following are the policy guidelines we follow: (include all language that is most appropriate for your office based on the work completed in this lesson)

- We notify our patients of the availability of our hardship policy in our Office Financial Policy.
- Patients who wish to access our Hardship Discount Fee Schedule must request this access and have their financial need verified.
- Financial hardship discounts are extended for a finite period of time, indicated on our Financial Hardship Agreement, a copy of which is attached hereto. **(By now you should have a Hardship agreement in place, in order to have this policy in place. If for any reason you do not, and need assistance with this please contact KMC University to learn about the options we have.)** After that time, financial hardship must be re-verified in order to extend the access to hardship discounts.
- We use the following as our guide to determine financial need: **(include all that apply)**
  - The Federal Poverty Guidelines
  - Proof of public assistance, such as Food Stamps, Social Security Disability, or other program.
  - Review of tax returns, recent pay stubs, W2 forms, or other proof of income
  - Proof of job loss or other financial catastrophe, such as death, divorce, or unexpected medical bills
  - Proof of bankruptcy settlement(either, include as many others as may apply)
- We offer hardship discounts to insured patients for copayments and deductibles **ONLY** when our contracts allow for such discounts and when financial hardship has been verified. We have confirmed with the following carriers that we are allowed to offer hardship discounts:
  - (include from the work you did in the exercise)
  - (include all that apply)
  - X
  - X
  - X
  - X
- We offer hardship discounts to insured patients who have insurance that we do not participate with on copayments and deductibles **ONLY** when we have verification that the carrier will allow for such discounts and when financial hardship has been verified.

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Professional Courtesy

- To whom do you offer courtesy fees?
- Staff? Family?
- Other DCs? Clergy? Military?
- What about when insurance is involved?
- Is it in writing?

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Legal & Safe Discounting

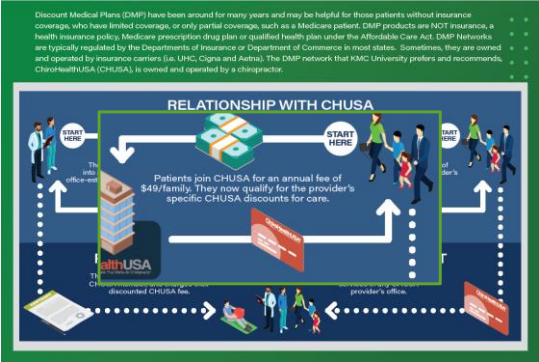
Membership in a DMPO

A discount medical plan organization uses a network to offer legal discounts for providers to charge to individuals enrolled in the plan

underinsured, and partially insured patients (e.g., Medicare patients)



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Caution Danger!

- Inducement Violations/Stark-Civil
- False Claims Act-Criminal and Civil
- Anti-Kickback Violations-Criminal

126

Anti-Kickback Statute

The Patient Solicitation Anti-Inducement Provision Section 1128A of the Social Security Act, enacted as part of the Health Insurance Portability Act (HIPAA)...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.**

Waiver of Copayment/  
Deductible

"Remuneration" includes, without limitation, waivers of **copayments and deductible amounts** (or any part thereof) and **transfers of items or services for free or for other than fair market value.** (See section 1128A (I) (6) of the Act.).

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Inducement Violations

Per the OIG: "incentives that are only nominal in value are NOT prohibited by [inducement law]  
**No more than \$15 per item or \$75 in the aggregate annually.** Even one free examination, x-ray, or therapy is a risk.

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Free Services = Violation

Department of Justice  
U.S. Attorney's Office  
Northern District of Iowa

FOR IMMEDIATE RELEASE  
Thursday, March 6, 2014

**Oelwein Chiropractor and Clinic Agree to Pay Nearly \$80,000 to Resolve False Claims Act Allegations Involving Free Electrical Stimulation**

Bradley Brown, D.C., from Oelwein, Iowa, and his clinic, Brown Chiropractic, P.C., have agreed to pay \$79,949 to resolve allegations Brown violated the False Claims Act by improperly billing Medicare and Medicaid for chiropractic adjustments after **providing free electrical stimulation** to beneficiaries to **influence their beneficiaries** to receive chiropractic adjustments from Brown. The government alleged that this conduct violated the Anti-Kickback Statute and, in turn, the False Claims Act. The claims at issue were submitted between January 1, 2012, and September 30, 2013.

The Anti-Kickback Statute's purpose, in part, is to protect patients and federal healthcare programs from fraud and abuse by limiting the influence of money or improper incentives on healthcare decisions. It is intended to ensure, among other things, that improper financial incentives do not compromise providers' medical judgments and that inappropriate considerations do not cloud beneficiaries' decisions when determining which provider to utilize and which services to obtain.

"Our office takes seriously our responsibility to safeguard taxpayer dollars and to ensure a level playing field for healthcare providers," said Peter E. Dwyer, Jr., United States Attorney for the Northern District of Iowa. "We appreciate Dr. Brown's cooperation in the investigation and hope this settlement sends a message to all providers that they must comply with all applicable rules and regulations or face consequences."

The allegations resolved by the settlement arose from an investigation led by the Department of Health and Human Services and conducted in conjunction with the State of Iowa's Medicaid Fraud Control Unit and the State of Iowa's Medicaid Program Integrity Unit. False Claims Act cases also arise under the qui tam or whistleblower provisions of the Act, which permit a private party with knowledge of false claims to bring suit on behalf of the United States and share therein any recovery.

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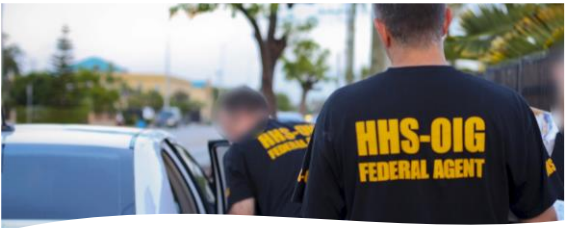
Costly Mistake  
Not Knowing the Rules and No SOP

**Oelwein Chiropractor and Clinic Agree to Pay Nearly \$80,000 to Resolve False Claims Act Allegations Involving Free Electrical Stimulation**

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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

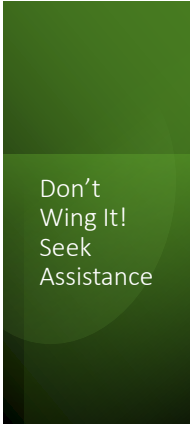
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Dual Fee Schedules

- Important to know what is and isn't a dual fee schedule
- Misrepresents charges to carriers
  - False Claims Act violation
  - May violate provider agreements

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PROVIDER COMPLIANCE TRAINING TAKE THE INITIATIVE. Cultivate a Culture of Compliance With Health Care Laws	
COMPARISON OF THE ANTI KICKBACK STATUTE AND STARK LAW*	
	THE ANTI KICKBACK STATUTE (42 USC § 1320a7b(b))
Prohibition	Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business
Referrals	Referrals from anyone
Types of Services	Any items or services
Intent	Intent must be proven (knowing and willful)
Penalties	Criminal: <ul style="list-style-type: none"><li>• Fines up to \$25,000 per violation</li><li>• Up to a 5 year prison term per violation</li></ul> Civil/Administrative: <ul style="list-style-type: none"><li>• False Claims Act liability</li><li>• Civil monetary penalties and program exclusion</li><li>• Potential \$5,000 CMP per violation</li><li>• Civil assessment of up to three times amount of kickback</li></ul>
	THE STARK LAW (42 USC § 1395aa)
Prohibition	Prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies
Referrals	Referrals from a physician
Designated Health Services	Designated health services
Intent	• No intent standard for overpayment (strict liability) • Intent required for civil monetary penalties for knowing violations
Penalties	Civil: <ul style="list-style-type: none"><li>• Overpayment/refund obligation</li><li>• False Claims Act liability</li><li>• Civil monetary penalties and program exclusion for knowing violations</li><li>• Potential \$15,000 CMP for each service</li><li>• Civil assessment of up to three times the amount claimed</li></ul>

Out of Network Patients

- If you represent full fee to the insurer, the patient must pay full fee
- What you bill is what you expect to collect, outside of any agreements/contracts
- Charge correctly, bill correctly, collect according to your office policy



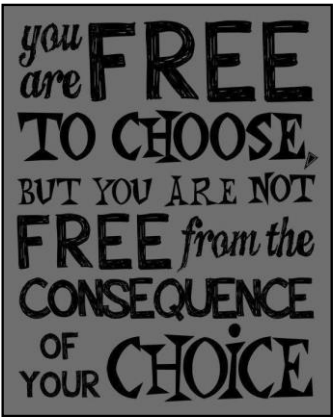
135



A Compliant Cash Pay Arrangement

- 5-15% discount guidance from the Feds
- Three states have rules on the books for TOS allowances
- Your fee is your fee is your fee
- Using a DMP like ChiroHealthUSA takes cash paying patients out of the actual fee range

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Risk Management Considerations- Patient Billing & Collections

Presented by: Kathy (KMC) Weidner, MCS-P, CPCO, CCPC, CCCA



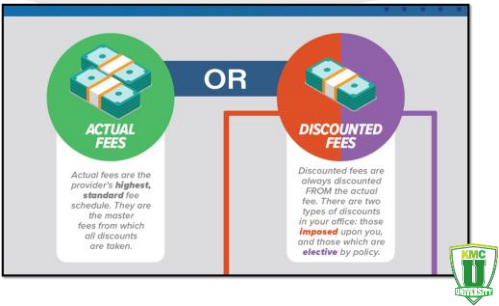
138

Objectives

- Identify common risky mistakes providers often make
- Acknowledge the rules surrounding patient finances
- Learn how to implement compliant patient billing and collection procedures

139

The Basics of Fees



140

Common Risky Mistakes

- Different fees for different people
- Write offs as a kindness
- Free exams or X-rays
- Ignoring payer requirements for advance notification of non-coverage
- Not offering a Good Faith Estimate

141

Is This Your Type of Fee Schedule?

- We have self-pay rate of \$40.00 for Medicare patient E/M. (We bill Personal Injury patients and insurance patients \$130.00 for E/M).
- We have a new patient, no insurance self-pay rate of \$65.00 for E/M, X-ray and adjustment.
- For our long-term patients, they pay a self-pay rate of \$25.00 an adjustment. Newer patients pay \$35.00 an adjustment.

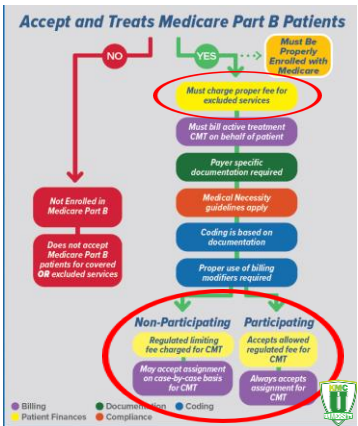
142

The fees set annually by Medicare for the three spinal Chiropractic Manipulative Treatment codes are called:  
**Regulated Fees**

your fees

143

Your Obligation When Agreeing to Accept and Treat Medicare Part B Patients



144



The Medicare Patient Financial Options

- If a statutorily excluded service such as an E/M, or X-ray is performed...
- you are **not mandated to bill those services**
  - if you verify the patient has secondary payer, you may bill Medicare in order to receive the denial
  - if you bill all the services rendered, and establish advance notice/financial agreement with the patient about their out-of-pocket cost you may collect your actual fee
  - if you are a member of a DMP (discount medical plan), and the patient signs up, you can implement a reduced rate in a compliant manner

145

Window to Patient Responsibility

A detailed review of all payments and patient out of pocket cost associated with a claim can be found on the Explanation of Benefits or Remittance Advice .



146

What is the Patient's Responsibility?

Medders, Minnie													Remark Code
Begin Service Date	End Service Date	Rendering NPI	POS	Units	Procedure Code	Modifiers	Billed Amount	Allowed Amount	Deductible	Copay Coinsurance	Adjust Codes	Paid Prev	
020323	020323	1234567890	11	1	99204 25, GY		250.00	0.00	0.00	0.00	PR	0.00	96, N425
020323	020323	1234567890	11	1	98940 AT		40.00	27.46	27.46	0.00	CO 45	0.00	96, N425
020323	020323	1234567890	11	1	99204 25, GY		250.00	0.00	0.00	0.00	PR	0.00	96, N425
Contractual Obligation													
Patient Responsibility													
Charge exceeds fee schedule/ maximum discount													
non-covered charges													
Statutorily Excluded service(s)													
\$ 307.46													
Procedure Code	Modifiers	Billed Amount	Allowed Amount	Deductible	Copay Coinsurance	Adjust Codes	Paid to Provider	Remark Code					
99204	25, GY	250.00	0.00	0.00	0.00	PR	0.00	96, N425					
98940	AT	40.00	27.46	27.46	0.00	CO 45	0.00						
97035	GY, GP	30.00	0.00	0.00	0.00	PR	0.00	96, N425					

\$ 307.46

147

MEDICARE MODIFIERS		
Modifiers Used Only With 98940, 98941, 98942		
Modifier	Description/Instruction	Effect on Medicare Payment
AT	Reporting Active/Carerive Treatment Indicates service rendered was medically necessary per Medicare guideline	Medicare will consider for payment.
GA	Waiver of Liability (ABL) on file for mandatory use Indicates maintenance care or visits exceed carrier screen	If patient selects ABL Option 1, you must bill Medicare. Medicare will deny as not medically necessary. Patient will be financially responsible.
GZ	Indicates you failed to collect ABL for maintenance care as required	Claim will be denied. Patient will not be deemed responsible for payment.
Modifiers Used with Statutorily Excluded Services		
Modifier	Description/Instruction	Effect on Medicare Payment
GY	Indicates statutorily non-covered item/service is rendered by a DC	Billing of these services is not required unless the patient requests. Patient is financially liable.
GX	ABL on file for voluntary use	Claim will be denied/patient financially liable; we don't recommend Medicare's official ABL form for voluntary use.
GP	Services delivered under an outpatient physical therapy plan of care	Use on PT modalities and procedures, along with GY to receive proper denial.

Patient is Financially Liable

GY which indicates that a statutorily non-covered service is rendered by the DC

A write-off or discount without consideration of federal rules is a Financial Risk



148

The Compliant Way..

For E/M, X-rays and Physical Therapy services you can...

- Bill Medicare for all services rendered based on patient request, or
- Bill Medicare for CMT (the covered service) only and collect from the patient your actual fee, for all other non-covered services, or
- Sign up for a DMP (discount medical plan) and encourage the patient to enroll for a discounted fee



149

A Quick Reminder

If you accept a Medicare patient, regulated discounts require you to accept the **regulated fee** for **CMT codes only**

150

The Medicare Advantage Plan Basics

- Part C requires providers to complete specific training for Fraud, Waste & Abuse, First-Tier Entity (FDR) and D-SNP (dual eligibles)
- Some payers require a pre-determination for non-covered services prior to rendering and billing the patient
- Most have a non-covered service advance notification form requirement
- Some require a specific modifier when reporting non-covered services
- PFFS plans may require you to bill the plan whether you are in network or out of network



151

Your Obligation When Agreeing to Accept and Treat Medicare Part C (Medicare Advantage) Patients



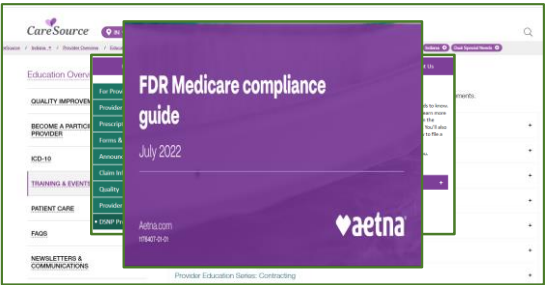
152

Medicare Advantage Financial Options

- Out of Network Doctors \***
- Charge the patient the same as you would a Part B beneficiary (limited fee) for covered services
  - Provide a superbill with your actual fee for all non-covered services, or if you are a member of a DMP (discount medical plan), and the patient signs up, you can implement a reduced rate in a compliant manner
- In Network Doctors**
- Follow the non-covered service billing requirement outlined by the payer
- \*PFFS plans may require you to file a claim and accept assignment

153

Required Training



154

The Pre-Service Determination Requirement for MA Plans

As a Reminder!

Medicare Advantage Plans may require the provider to complete

- Fraud Waste & Abuse Training
- FDR Compliance Training
- Dual Eligibility (D-SNP compliance) Training
- A Pre-Determination Form for non-covered services

155

What is the Patient's Responsibility?

Humes, Henry										Remark Code
Date of Service	POS	Units	Procedure Code	Modifiers	Amount Billed	Amount Allowed	Deductible	Copay	Insurance	
012723	11	1	98941 AT		50.00	32.27	0.00	6.45		CO 45
012723	11	1	97035 GP, GY		50.00	0.00	0.00	0.00		204
012723	11	1	G0283 GP, GY		50.00	0.00	0.00	0.00		204
<b>\$ 56.45</b>										
Contractual Obligation										
012723	11	1	98941 AT		50.00	32.27	0.00	6.45	25.82	CO 45
012723	11	1	97035 GP, GY		50.00	0.00	0.00	0.00	0.00	204
012723	11	1	G0283 GP, GY		50.00	0.00	0.00	0.00	0.00	204
Contractual Obligation										
Charge exceeds fee schedule/ maximum allowable										
This service is not covered under the patient's current benefit plan										

156

The Compliant Way..

For Non-Covered or Excluded Services...

- Identify what is considered non-covered by EACH payer, do not assume.
- Review the notification requirements, billing limitations, and balance billing laws as outlined by the payer, and federal and state laws.
- Develop an advance notice process with signed acknowledgment if one is not provided by the payer.
- Set your fees according to the rules. Be sure to create billing policies for every plan type, especially PFFS.



157

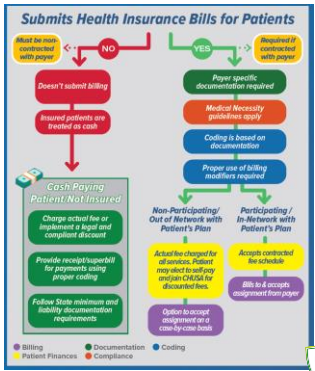
Insured Patients & Imposed Discounts

- Follow the payer's reimbursement guidelines
- Refrain from writing off copay's, coinsurance, or non-covered services
- Locate the payer's advance notice of non-covered service requirements (if applicable)



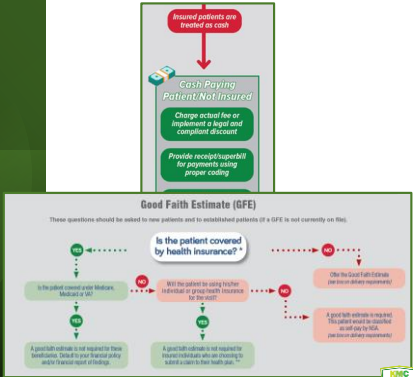
158

The Out of Network Doctor Who Submits Claims



159

The Out of Network Doctor Who Does NOT Submit Claims



160

Good Faith Estimate

"Health care providers and health care facilities are required under PHS Act section 2799B-6 to furnish a **notification of the good faith estimate of expected charges to an uninsured (or self-pay) individual** who schedules an item or service..."



161

Self-Pay Patients

Uninsured

Do not plan to use their insurance benefits to pay for the services provided by the physician



162

Good Faith Estimate  
Timely Delivery Requirements

GFE Delivery Requirements

If appointment is made:

10 business days in advance, the GFE must be provided within three business days

3-9 business days in advance, the GFE must be provided within one business day

less than 3 days in advance you ARE NOT required to provide a GFE in writing.

Notify orally upon scheduling (provide estimate of initial evaluation).

NOTE: If the patient requests a GFE on their own, while at the clinic or just shopping for care, you

need to provide one within three days of date of request. Keep all copies of GFEs as part of the

medical record and provide a hard copy or electronic to the patient or prospective patient.

163

Initial Visit  
GFE Customization

Good Faith Estimate

John Doe Chiropractic & Wellness Center  
Dr. John Doe  
TIN: 20-0000000

Patient Information

John Doe

DOB: 04/02/1997

Estimate

SERVICE/ITEM	DESCRIPTION	DIAGNOSTIC CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Exam (Evaluation)	no back, shoulder, neck, pelvis		1	145.00	145.00
Imaging	diagnostic		1-2	105.00	210.00
Electrical Stimulation	muscle spasm		1	36.00	36.00

Total Expected Charges \$ 521.00

Scheduled Appointment Date: May 3, 2022

Check box if not scheduled

Estimate

SERVICE/ITEM	DESCRIPTION	DIAGNOSTIC CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Exam (Evaluation)	no back, shoulder, neck, pelvis		1	145.00	145.00
Imaging	diagnostic		1-2	105.00	210.00
Electrical Stimulation	muscle spasm		1	36.00	36.00

Total Expected Charges \$ 521.00

164

Good Faith Requirements

Need to post notice of patient's right to receive a GFE (in clinic and on website)

Need to OFFER a GFE to all patients who are uninsured or insured but not filing a claim with their insurance

GFE must be customized according to the recommended treatment and within \$400.00 of actual billed charges- AVOID Price List documents

165

REQUIREMENTS  
STANDARDS  
POLICIES  
COMPLIANCE  
TRANSPARENT  
RULES  
RELAW  
JULATIONS

The  
Compliant  
Way

- If you represent full fee to the insurer, the patient must pay full fee
- What you bill is what you expect to collect, outside of any agreements/contracts
- Charge correctly, bill correctly, collect according to your office policy



166

What  
about  
these  
scenarios?

- We have a new patient, no insurance **self-pay rate** of \$65.00 for exam, X-ray and adjustment.
- We have a **self-pay rate** for children of established patients- \$10.00 an adjustment.
- For our long-term patients, they pay a **self-pay rate** of \$25.00 an adjustment. Newer patients pay \$35.00 an adjustment.

167

The RISKY  
Self-Pay  
Rate



168





Dual Fee Schedules

- Charging insurance companies more than self-pay (Cash) patients
- False Claims Act and Inducement Violations
  - May violate provider agreements

169



Inducement Violations

Per the OIG, “incentives that are nominal in value are NOT prohibited by [inducement law]” No more than \$15 per item or \$75 in the aggregate, annually.  
Even one free or improperly discounted examination, x-ray, or therapy puts you at risk

170

Time of Service Discounts

Payment And Co-Pays Are Due At Time Of Service

- Discount should be based on bookkeeping savings
  - May or may not be defined
  - Often indefensible or unreasonable
  - May not be permissible for federally insured patients

171

Anti-Kickback Violations

A person that 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.

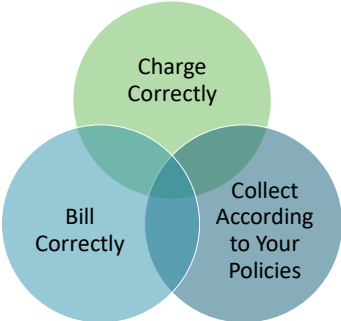
The statute defines “remuneration” to include, without limitation, waivers of copayments and deductible amounts (or parts thereof) and transfer of items or services free of charge or for other than fair market value.

172

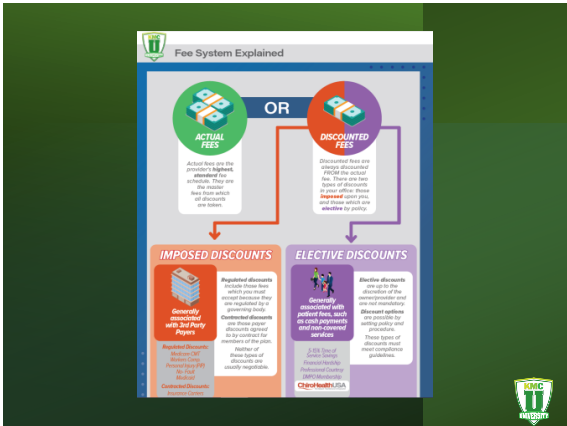


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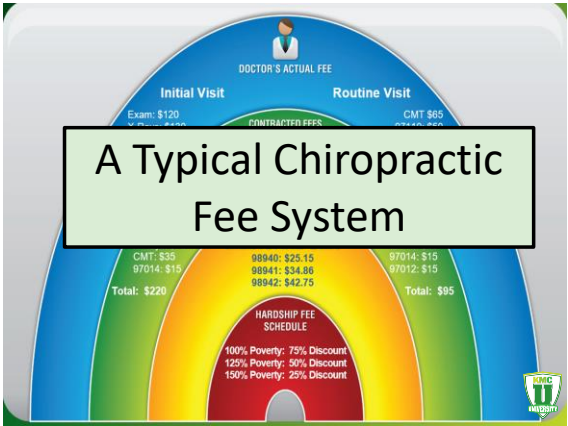
Key to All Finances



174



175



176

Know All Your Imposed Discounts

Often Overlooked...

- Personal Injury
- VA
- Workers Comp
- Medicaid

177

Worker's Compensation (WC) Fee Schedule

- Most states have a regulated WC fee schedule
- Federal WC has its own fee schedule and coverage
- Fees are found on the state WC website



178

Personal Injury (PI) Fee Schedule

- PI fees are not regulated
- At fault vs. no-fault
- Personal Injury Protection (PIP) may be based on Medicare
- No-Fault often has a regulated fees
- Tort states, med-pay, etc. are usually not regulated



179

Medicare Non-Par Doesn't Mean Wild West!



180

### Mandatory Billing Might Apply

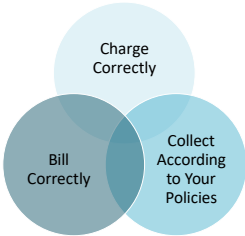
- When a Medicare patient receives coverable, AT modifier-worthy care, the doctor must bill Medicare
- Non-covered care MAY have to be submitted as well
- **Third Party Payer Contracts** may include mandatory billing rules



181

### Medicare Billing Requirements

- Mandatory billing rules require all (Part B) -AT CMTs to be submitted by the provider
- Make patients responsible for their cost sharing, **if not QMB**
- Submit within the timely filing guidelines



182

### PATIENTS RIGHTS

- o get considerate and respectful
- o Information
- o give informed consent
- o privacy
- o Confidentiality
- o Obtain reasonable care and
- o get copies of all medical
- o know whether patient is part of research
- o get details of Treatment and
- o expect continuity of Care
- o obtain Second opinion

### Consumer Empowerment

You may be required to bill when they ask you to, even for non-covered services

Regardless of your participation level, the patient decides whether you bill Medicare Part B

They can change their minds and you must comply

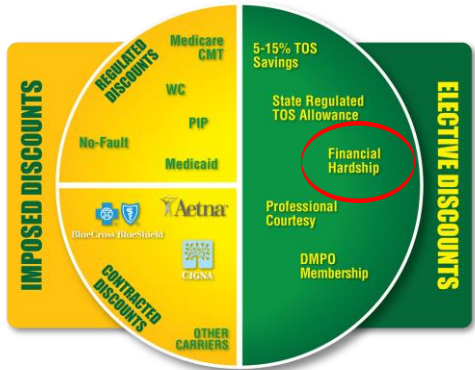
Advance Notice of out-of-pocket cost is required by some payers. It is federal law for uninsured individuals

### Elective Discounts the Compliant Way



183

184



185



### Mistakes and Blunders

- What may NOT be financial hardship?
- No insurance
  - High deductible
  - I don't want to pay that much
  - My other doctor didn't charge my co-pays

Don't confuse a hardship discount with a general discount!

186



# Hardship Fees

- Your hardship agreement can co-exist with other fee schedules
- You must set the standard, up front, have qualifying factors, and verify eligibility
- Use a standardized form and system



187

# Medicare's 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



188

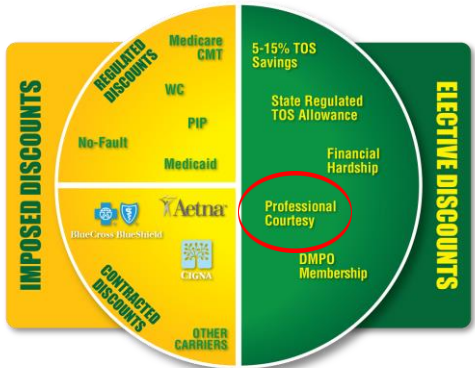
Family Unit Size	100%	133%	166%	175%	200%	250%
1	\$14,580	\$19,440	\$25,920	\$23,250	\$27,000	\$33,750
2	\$19,770	\$26,360	\$35,150	\$31,000	\$36,750	\$45,930
3	\$24,960	\$33,280	\$44,320	\$39,750	\$47,250	\$59,070
4	\$30,150	\$39,500	\$52,660	\$47,625	\$57,000	\$71,250
5	\$35,340	\$46,770	\$63,720	\$57,375	\$68,250	\$85,320
6	\$40,530	\$53,370	\$71,820	\$65,250	\$78,000	\$97,500
7	\$45,720	\$60,280	\$80,360	\$73,125	\$87,750	\$109,680
8	\$50,910	\$67,200	\$88,940	\$81,000	\$97,500	\$121,860

189

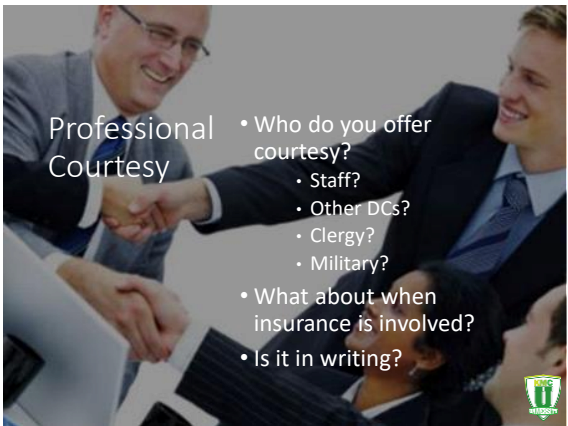
**Hardship Internal Office Policy**

190

**Hardship Fees for Qualifying Patients**



191



# Professional Courtesy

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



192



Professional  
Courtesy  
Office Policy

- Define the terms
- Include restrictions
- Be consistent

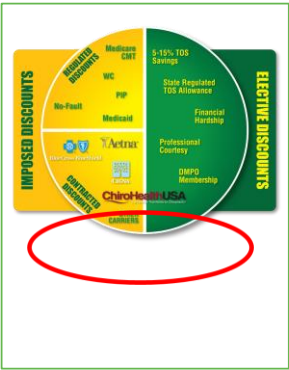
We offer discounts to the following groups at the following levels:

- Staff members of [insert practice name], are offered treatment in the office at [insert percent] discount.
- Durable medical equipment, nutritional supplies, or other hard good items are offered to staff members [choose, at doctors cost, a certain discount, or other choice]
- Immediate family members of our staff at [insert practice name] are offered treatment [insert any applicable discount or consideration]
- For the purpose of this policy, immediate family members are considered to be [define, such as spouse and children, parents, etc]
- Fellow Chiropractic physicians in our community are offered treatment in the office at a [insert percentage or other consideration] discount.

NOTE: In circumstances where auto accidents, worker's compensation accidents, other personal injury or other medico-legal situations occur, where reporting actual fees is necessary, and the party receiving professional courtesy wishes to receive treatment at this office, the party may decide to opt out of this policy, and elect to be charged our 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 full fees in order to have them reported to a third party for medico-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 unmet deductible, as with any other patient.

For patients to legally receive discounted fees, they could join a discounted medical plan Network



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194



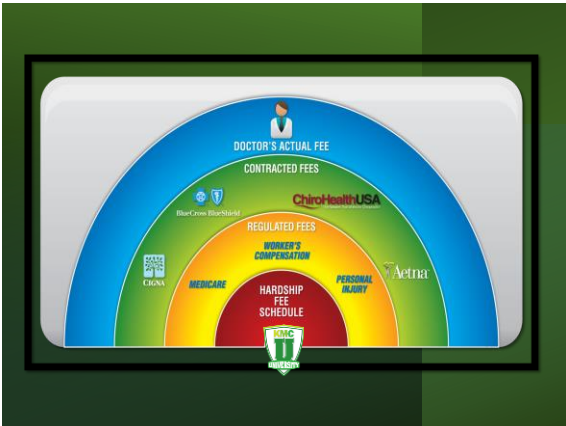
195

Legal & Safe  
Discounting

Membership in a DMPO allows you to bill your actual fees when necessary and offers the protection of a contract that allows you to offer network-based discounts to your cash, underinsured, and partially insured patients (e.g., Medicare patients)



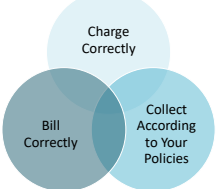
196



197



Collect  
According to  
Your Policies



198

# Collecting Money for Services

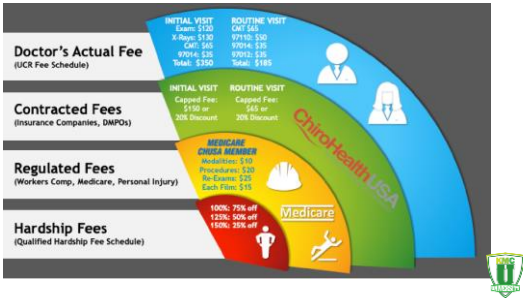
How you collect money for services can be problematic for compliance

- You can't just waive charges because you make more money from the 3<sup>rd</sup> party payer
- You can't charge a patient one fee for a particular service and then charge the 3<sup>rd</sup> party payer a different fee



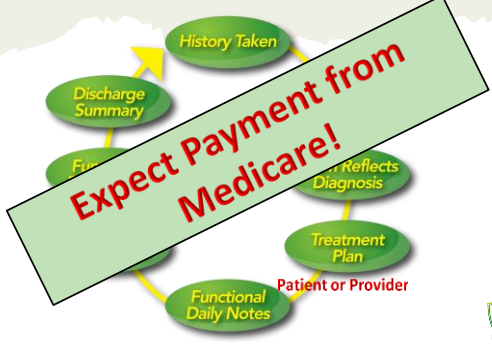
199

# Patient Responsibility



200

# Medicare Active Episodes of Care



201

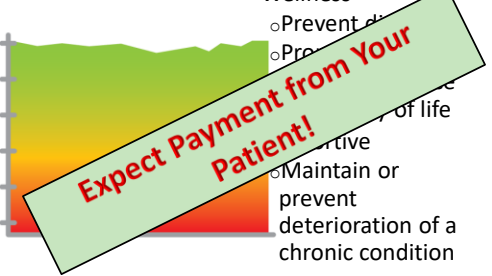


# Medicare Patients

- It's OK to collect 20% co-pay or known deductible at TOS if participating
- Collect full limiting fee for Part B if Non-Par
- If service is denied, you must refund to patient OR you must appeal
- Medicare IVR/portals can let you know if deductible is met for the year
- Always based on allowable amount if participating

202

# Maintenance



203

# Three Choices for Fees in Maintenance Care

- Charge Medicare allowable fee or limiting fee
- Charge your actual fee
- Charge a discounted fee for maintenance if the patient qualifies and you offer this to ALL types of patients
- Codify this in your compliance policy



204

Collect Actual Fee  
for Maintenance  
CMT

- As the manual states, it's OK to begin charging ACTUAL fee during maintenance with signed ABN
- Requires carefully worded FROF and discharge discussion of fees
- We recommend Par providers BILL actual fee
- Non-Par Providers must bill Limiting Fee



205



Publish a  
**Maintenance  
Fee Schedule**  
Anyone Can Access

- The safest, and cleanest way to do this is to join a DMPO network like ChiroHealthUSA
- Within that fee schedule, post a fee for maintenance CMT, regardless of levels
- Anyone that is a member can access that fee schedule

206

Medicare Part C Patients

- If participating, bill the plan and follow the fee schedule
- If not participating, decide whether to bill it (not suggested) and collect according to fee schedule\*
- If you do not bill, keep to the Medicare Fee Schedule you follow for Part B

\*PFFS plans may require the provider to bill all services and accept assignment



207



Payment  
Plans

- Once you have charged and billed correctly, you may collect according to your written policy
- OK to allow patients to pay their portion on a monthly payment plan

208

Payment Plan Compliance

- Use of proper fees to calculate patient responsibility
- Appropriate estimate of medically necessary care to be paid by 3<sup>rd</sup> party
- Automatic payments from credit card handled properly
- No discounts given on 3<sup>rd</sup> party reimbursable portion of care
- KMC University prefers the **Cash Practice System®**



209

Two Kinds of  
Policy

- Internal Financial Policies
  - Compliance policies
  - "This is how we do it here"
- Public Financial Policy
  - "This is how your financial relationship with us works"



210

Internal Financial Policy

Insert Practice Identifying Information

Sample Policy for:

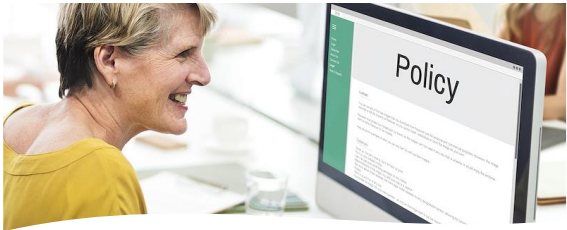
Contracted and Actual Fee Schedules

It is the policy of this office to have one actual fee schedule with fees assigned to each service that is provided. This actual fee is based on regional average for each service, average reimbursement from third party payers, and the practice's cost vs. collection for the services rendered. This fee schedule is reviewed a minimum of annually and updates are posted for appropriate notification of patients.

This office **does/does not** participate with managed care organizations, and therefore (does/does not) have contracted fee schedules which are used for patients who are eligible. These contracts are stored in an orderly and easily accessible fashion, and reviewed at least once a year.

This office abides by regulated fees for programs such as Medicare and Worker's Compensation in our state. Patients who qualify for these regulated fee schedules are charged only within the legal boundaries of these regulated fee schedules.

211



A Public Financial Policy

- Policy sets boundaries and affirms agreements
- An informed patient tends to be a compliant patient
- Clear explanation of policies allows for flexibility, if necessary, on a case-by-case basis

212

Don't Let This Be the First Time They Hear It

- Introduce the nuances of your policy on first phone call\*
- Don't fear mentioning money
- Set expectations
- Have an idea of how you'll answer any question

\*Keep in mind Good Faith Estimate requirements



213

Reduced Risk with a Financial Policy

Patients understand that they've come to the right place

Patients understand their financial responsibility for today's visit and that details will happen after ROF visit

Patients pay something toward their financial responsibility today


Patients join CHUSA if they wish to access discounted fee schedule, if appropriate

Patients sign general office financial policy

214

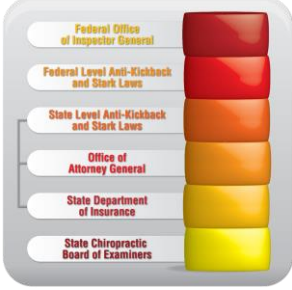
Do These Scenarios Sound Like You?

- We have a patient who owes \$40.00 for a bill
- We have a patient who owes \$130.00 for a bill
- We have a patient, no insurance, who owes \$65.00 for a bill
- We have a patient who owes \$25.00 for a bill
- We have a patient who owes \$35.00 for a bill



215

Patient Financial Compliance is Not Optional



216



### Take Aways

- Set your **fees** and update annually
- Know the payer's terms regarding non-covered services and advance notice
- Get to know the federal and state rules that impact charges and patient responsibility
- Establish an advance notice process for patient out of pocket cost that includes a financial policy/agreement
- Establish compliant hardship and professional courtesy fees
- Consider a DMP for the many non-covered services with Medicare and Commercial payers




217

**How to obtain your  
CE Credits...**

Because you are on the Webinar now,  
you must take the four question quiz  
**BEFORE MIDNIGHT ET TONIGHT**

If you **do not**, you must watch the entire webinar again  
on the ChiroCredit site before the end of the month  
and take the quiz immediately after.

**THE CODE FOR THE LIVE WEBINAR IS: 129456**



KMCUniversity.com/CEU | (855) 832-6562

218

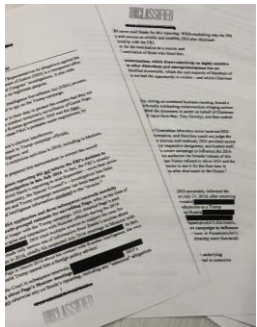
### Social Media Tips



219

### De-Identify Information

- Keep it vague!
- Clinical vignettes posted on social media concerning patients must have all personal identifying information and any revealing references removed.
- Avoid the description of rare medical problems, accident-related details, and specific time frames or locations.



220

### Ethics & Boundaries

Best Business Practice is to avoid 'Friend' request on a physician's Facebook page

*Providers who interact with their patients on social media may be violating the Patient-Provider boundary*

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### What Can You Say?



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Make  
Statements  
Not  
Discussions

- Change in Office Hours
- Weather or Holiday Closures
- Advertise new services
- Educate patients

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### Establish a Process

- Who on the team is responsible for responding?
- Do they know the HIPAA rules?

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FOR IMMEDIATE RELEASE  
June 5, 2023

Contact: HHS Press Office  
202-690-6343  
media@hhs.gov

### HHS Office for Civil Rights Reaches Agreement with Health Care Provider in New Jersey That Disclosed Patient Information in Response to Negative Online Reviews

New Jersey psychiatry practice pays \$30,000 to settle complaint about impermissible disclosure of protected health information by disclosing this information in online review

Today, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR) announces a settlement with Manasa Health Center, LLC, a health care provider in New Jersey that provides adult and child psychiatric services. The settlement resolves a complaint received by OCR in April 2020, alleging that Manasa Health Center impermissibly disclosed the protected health information of a patient when the entity posted a response to the patient's negative online review. Following an OCR investigation, potential violations of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule include impermissible disclosures of patient protected health information in response to negative online reviews, and failure to implement policies and procedures, with respect to protected health information. Manasa Health Center paid \$30,000 to OCR and agreed to implement a corrective action plan to resolve these potential violations.

"OCR continues to receive complaints about health care providers disclosing their patients' protected health information on social media or on the internet in response to negative reviews. Simply put, this is not allowed," said OCR Director Melanie Fontes Rainer. "The HIPAA Privacy Rule expressly protects patients from this type of activity, which is a clear violation of both patient trust and the law. OCR will investigate and take action when we learn of such impermissible disclosures, no matter how large or small the organization."

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### Test Your Social Media Privacy Standards..

If a patient were to comment negatively on a social media page about their treatment, which of the following would **not** be a compliant response?

- A. I am so sorry that you did not benefit from the treatment at our clinic. Please give us a call. We want to make this right with you.
- B. At Heavenly Chiropractic we see success stories each day. Please check out our About Us page for additional information and contact details.
- C. All of the above

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### Responding to a bad review...

*"I had to wait for over an hour to be seen by Dr. Jones. This office does not respect the patient's time."*

The HIPAA Compliant Response:

"When scheduling patients, it's our office policy to adjust the time with the doctor as necessary for each patient's needs to keep our schedule on track. As a result of emergency situations, it is possible for us to be behind schedule from time to time."

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Patient post a negative opinion about the type of treatment..

Use this as an opportunity to educate the public in general on your treatment or technique, the reasons behind this approach and the general outcome or results.

**Statement format only.**

**Never refer to specifics** about the patient's situation or treatment.

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Responding to a positive review...

" I love Dr. Jones and his staff. He was able to address my low back pain in just two adjustments."

HIPAA Compliant Response :

"At Heavenly Chiropractic we utilize a variety of techniques to address dysfunction and pain. Each day we witness the impact of chiropractic treatment on people's lives. It is one of the best things about being a Doctor of Chiropractic. We love our patients!"

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A medical related inquiry...

Providers can also expose themselves to lawsuits if they respond to a question sent via social media by providing medical advice

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Good Intentions....

Nurse posted on a patient's hospital sponsored communication page encouraging words. "I know the last week has been difficult. Hopefully, the new happy pill will help, along with the increased dose of morphine. I will see you on Wednesday."

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Do Not 'Vent' Online

An emergency medicine physician was reprimanded by the Rhode Island State Board for "unprofessional conduct" and was fined after making comments on Facebook about a patient. The physician did not mention the patient's name in the post; however, sufficient information was included that allowed others within the community to identify the patient.

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Patient Consent

**Patient Portal**

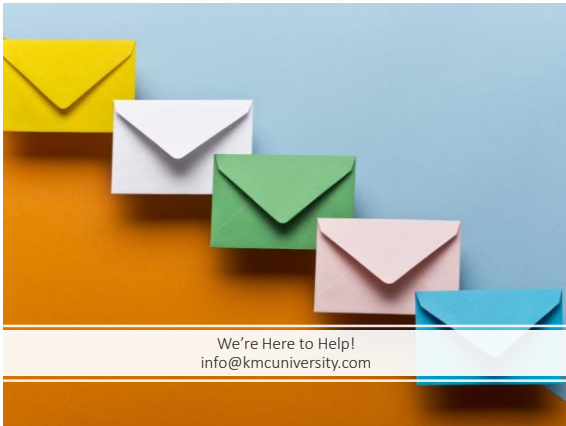
The patient's consent is a critical issue to consider when using cloud-based applications to communicate to the patient.

I Agree ☐

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you are **FREE** TO CHOOSE, BUT YOU ARE NOT **FREE** from the CONSEQUENCE OF YOUR CHOICE

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