Adventures in Documentation and Risk Management

Presented by:
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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?

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Your Passion is Also a Regulated Business

Documentation

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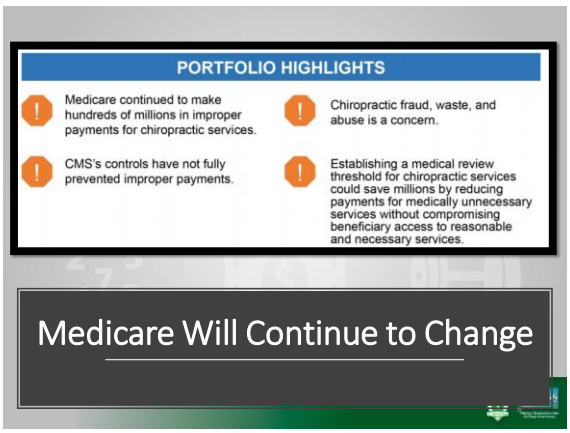

Medicare Will Continue to Change

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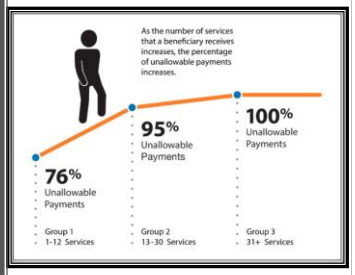
Not Really Rocket Science



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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

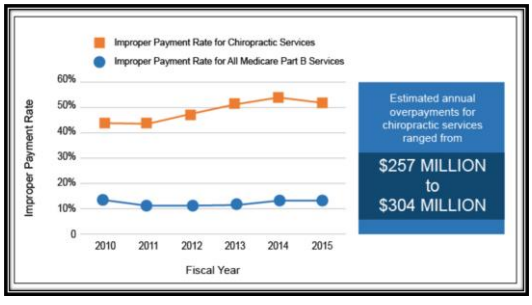

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Table G1: Improper Payment Rates by Service Type: Part B

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	346	$161,340,225	31.3%	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[20] Errors: Part B

Part B Services (BETOS 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%) - 2.6%

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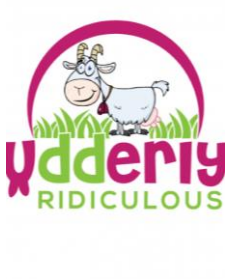
The Gospel According to KMC…

"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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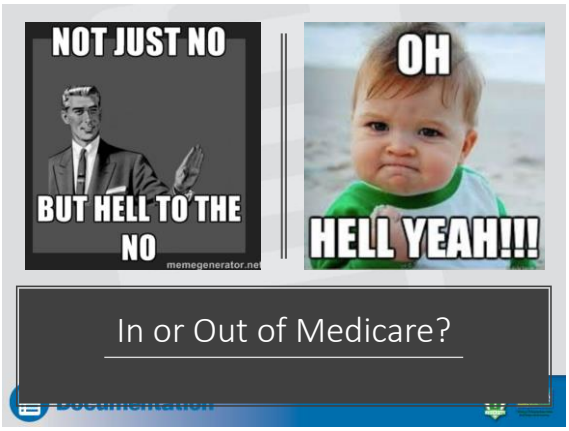

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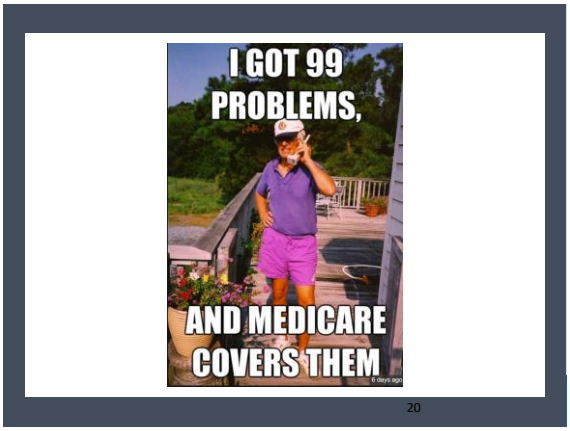

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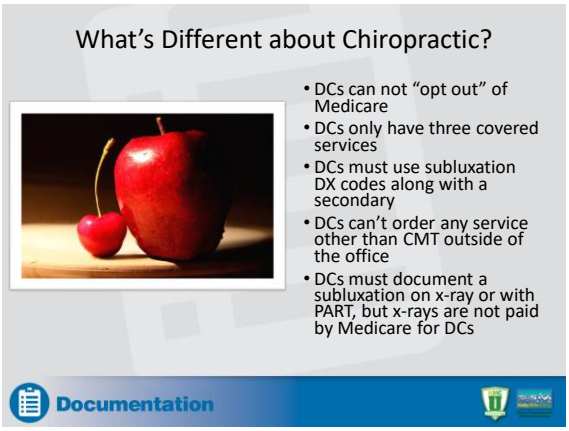

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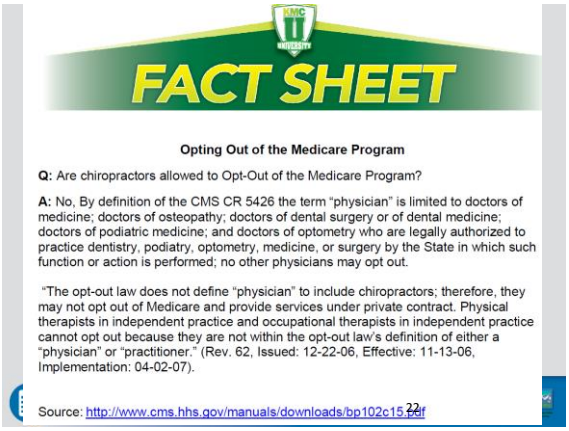

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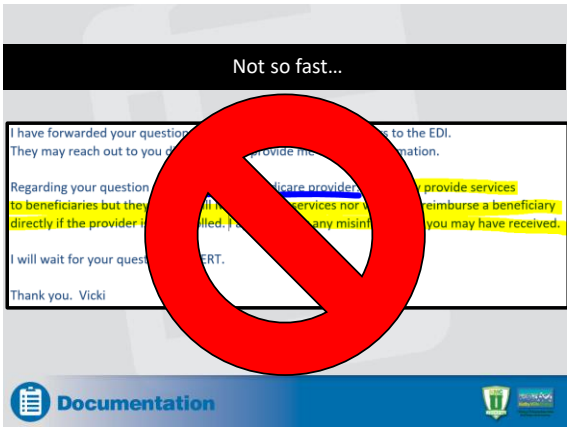

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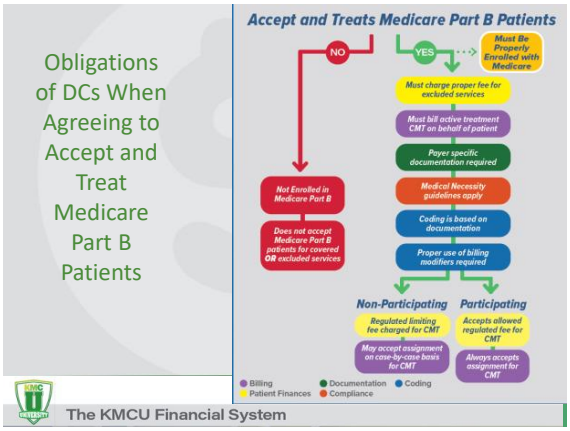

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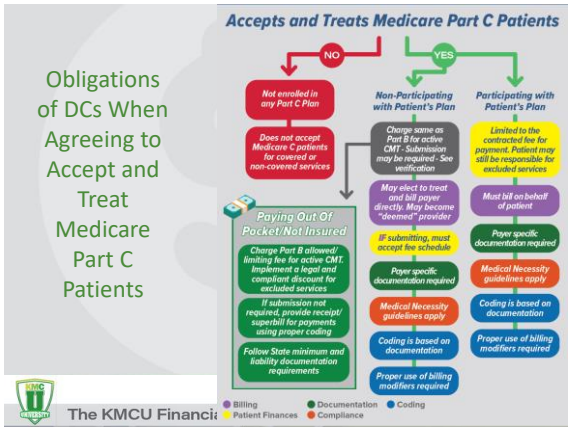

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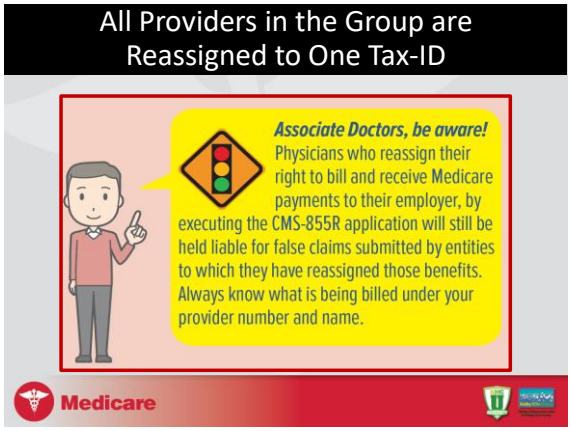

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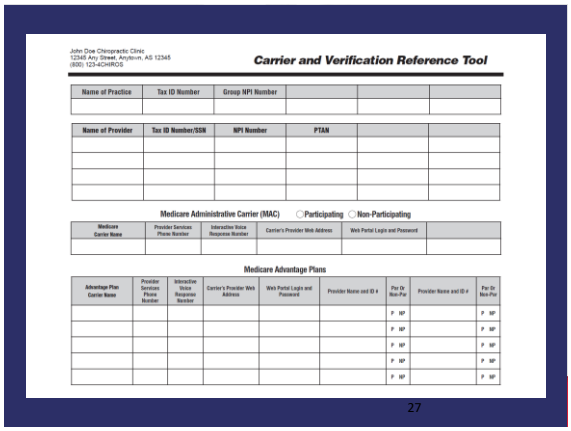

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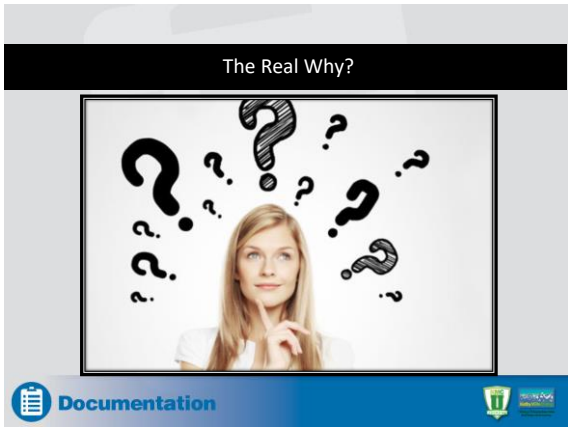

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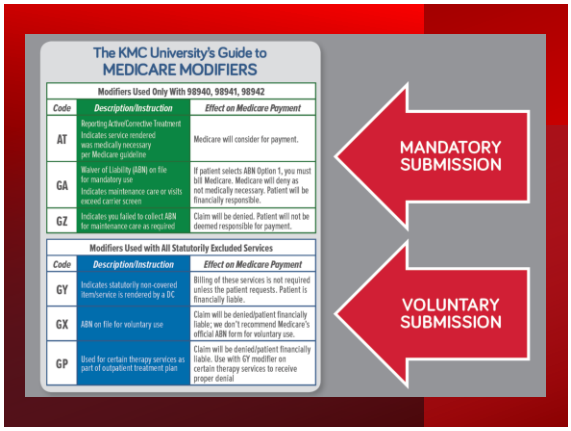

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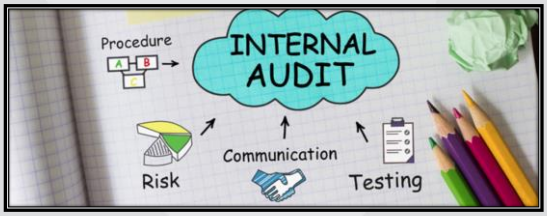
Conduct Internal Audits



Compliance

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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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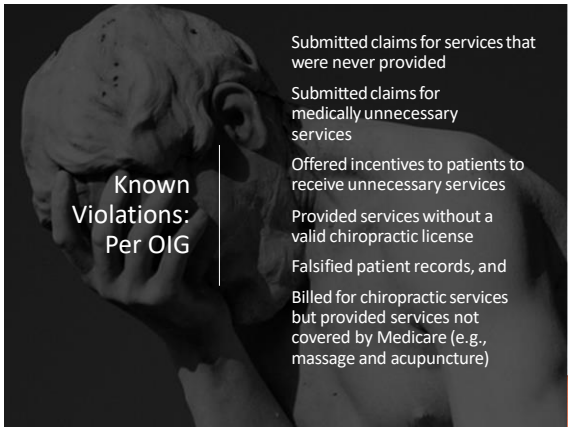

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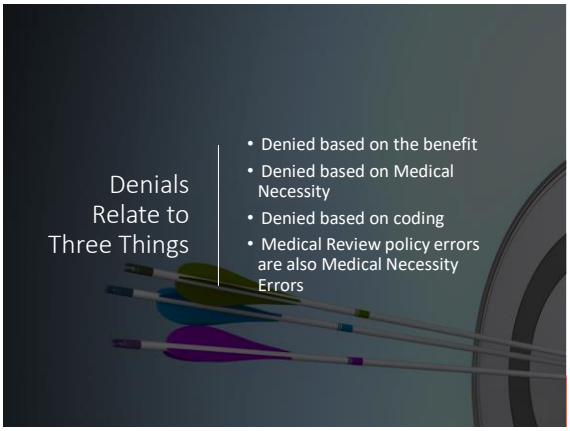

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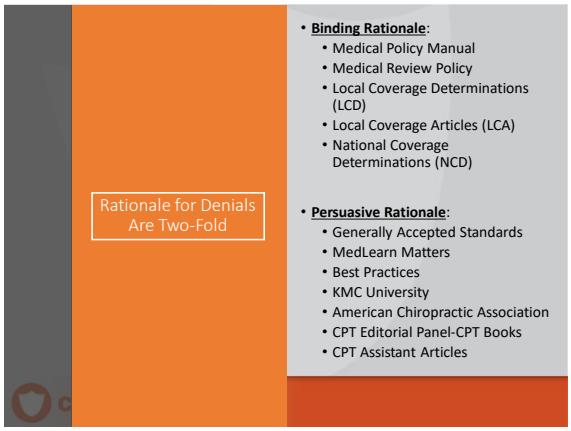

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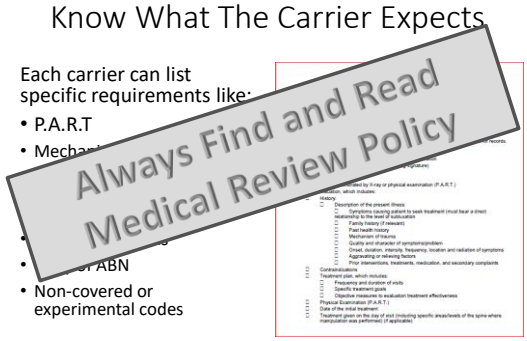

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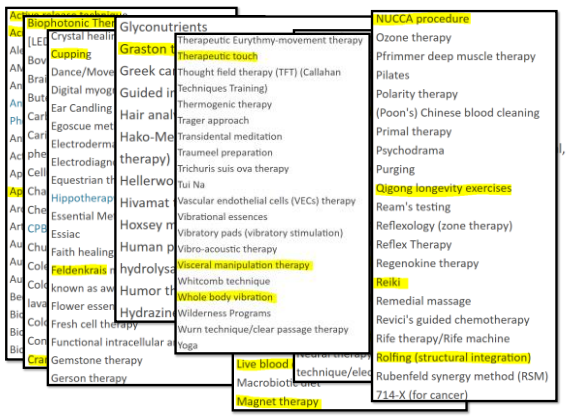

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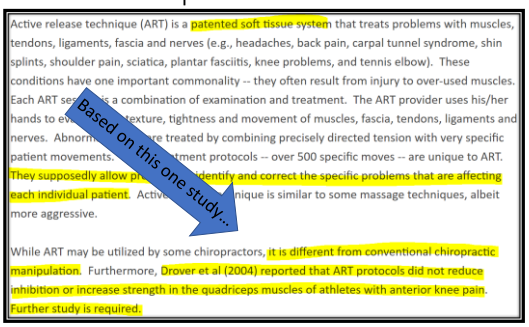

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Review E/M and NP Ratios

ion and Management (E/M) Codes

ation & gement	Total	Total by Category	Ratios by Categor
99201	0		0.00%
99202	0		0.00%
99203	1110	1110	100.00%
99204	0		0.00%
99205	0		0.00%
99211	0		0.00%
99212	3		0.22%
99213	1374	1377	99.78%
99214	0		0.00%
99215	0		0.00%
99241	0		0.00%
99242	996	996	100.00%
99243	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

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	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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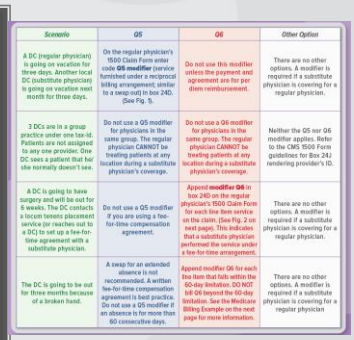
Who Was the Provider?



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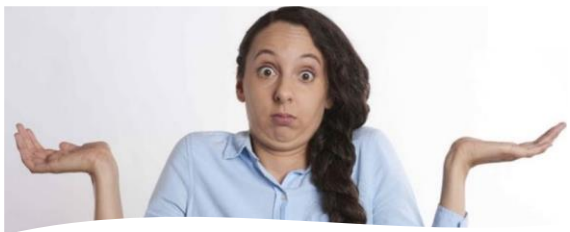

What Could Be Wrong?

- 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 Categ
97010	0		0.00
97012	1242		100.0
97014	0		0.00
97016	0	1242	0.00
97018	0		0.00
97022	0		0.00
97024	0		0.00
97026	0		0.00
97110	0		0.00
97112	0		0.00
97113	0		0.00
97116	0	0	0.00
97124	0		0.00
97139	0		0.00
97140	0		0.00
97150	0	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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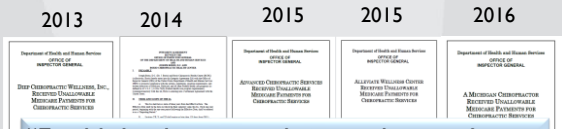
Outliers Are Audited & Made Example

2013 2014 2015 2015 2016



"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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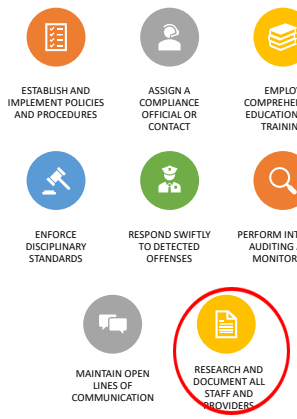
7 Elements of an OIG Compliance Program (+1)



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Documentation Great or Meh?

Documentation

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Know your Audience

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

Documentation

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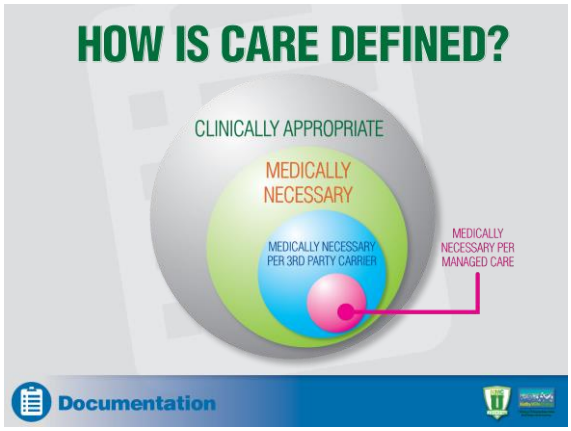

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Heightened Awareness of Hot Spots

- 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

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

Subsequent Visits

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

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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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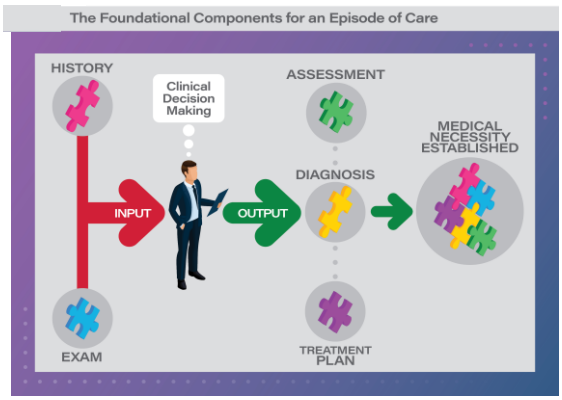

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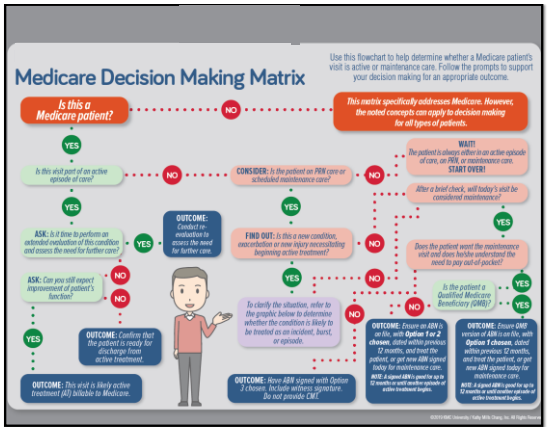

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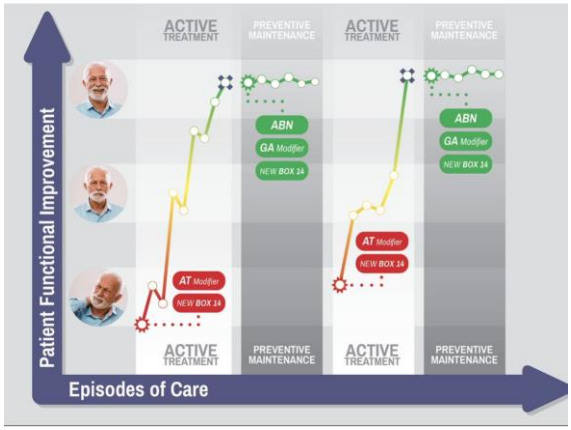

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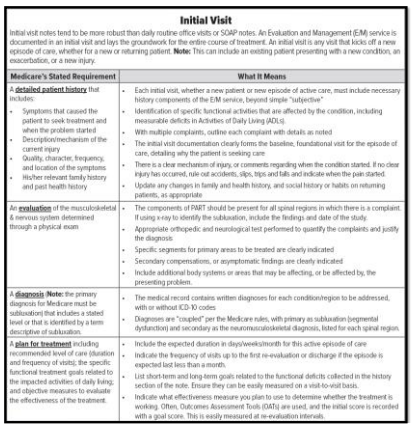

Initial Visit

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. **Note:** This can include an existing patient presenting with a new condition, an exacerbation, or a new injury.

Medicare's Stated Requirement	What It Means
A **detailed patient history** that includes: • Symptoms that caused the patient to seek treatment and when the problem started • Description/mechanism of the current injury • Quality, character, frequency, and location of the symptoms • His/her relevant family history and past health history	• 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" • Identification of specific functional activities that are affected by the condition, including measurable deficits in Activities of Daily Living (ADLs). • With multiple complaints, outline each complaint with details as noted • The initial visit documentation clearly forms the baseline, foundational visit for the episode of care, detailing why the patient is seeking care • 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. • Update any changes in family and health history, and social history or habits on returning patients, as appropriate
An **evaluation** of the musculoskeletal & nervous system determined through a physical exam	• The components of PART should be present for all spinal regions in which there is a complaint. If using x-ray to identify the subluxation, include the findings and date of the study. • Appropriate orthopedic and neurological test performed to quantify the complaints and justify the diagnosis • Specific segments for primary areas to be treated are clearly indicated • Secondary compensations, or asymptomatic findings are clearly indicated • Include additional body systems or areas that may be affecting, or be affected by, the presenting problem.
A **diagnosis** (**Note:** the primary diagnosis for Medicare must be subluxation) that includes a stated level or that is identified by a term descriptive of subluxation.	• The medical record contains written diagnoses for each condition/region to be addressed, with or without ICD-10 codes • Diagnoses are "coupled" per the Medicare rules, with primary as subluxation (segmental dysfunction) and secondary as the neuromusculoskeletal diagnosis, listed for each spinal region.
A **plan for treatment** 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.	• Include the expected duration in days/weeks/month for this active episode of care • Indicate the frequency of visits up to the first re-evaluation or discharge if the episode is expected last less than a month. • 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 visit-to-visit basis. • Indicate what effectiveness measure you plan to use to determine whether the treatment is working. Often, Outcomes Assessment Tools (OATs) are used, and the initial score is recorded with a goal score. This is easily measured at re-evaluation intervals.

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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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What Good Looks Like

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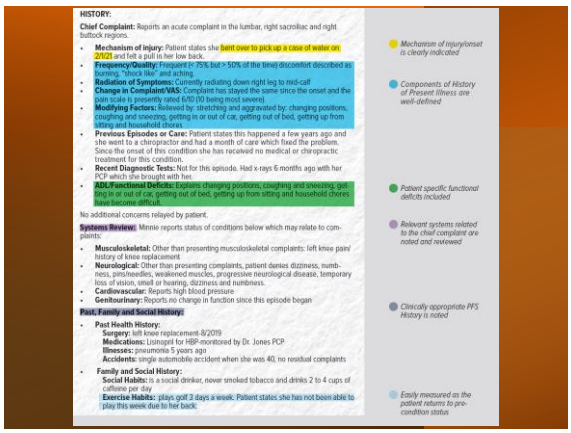

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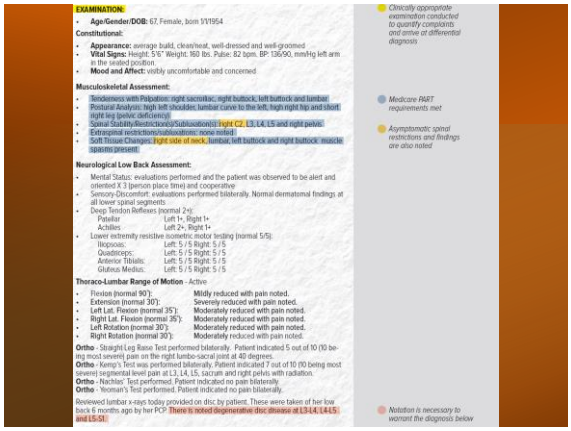

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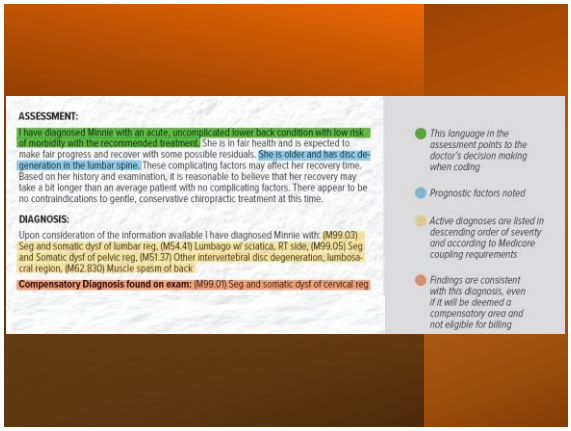

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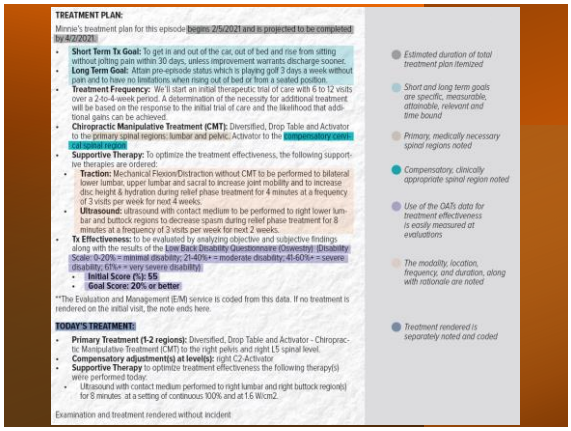

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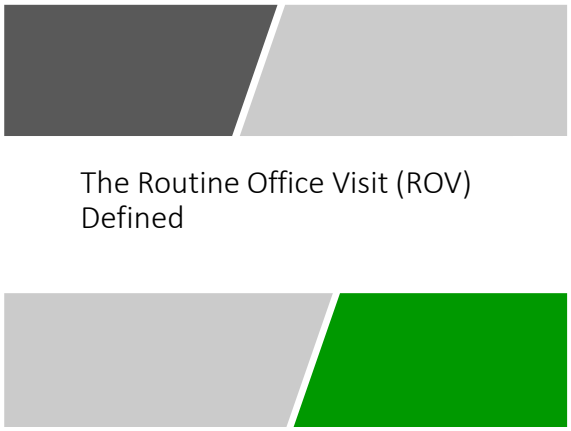

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Last Step: Doctor Fixing

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

73

Medicare Documentation Guidelines

Initial Visit

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

Subsequent Visits

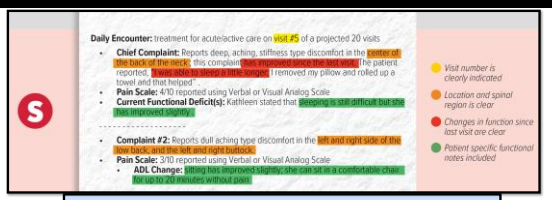
- History
- Review of chief complaint
- Physical Exam (PART)
- Document daily treatment
- Progress related to treatment goals/plan (Assessment)

74

What Good Looks Like

75

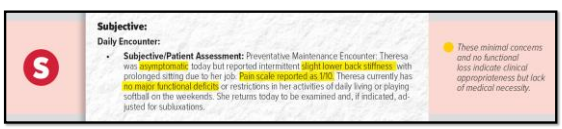
Active Treatment Routine Office Visit (ROV) Subjective



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

76

Preventive Maintenance Visit Subjective



- 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

- 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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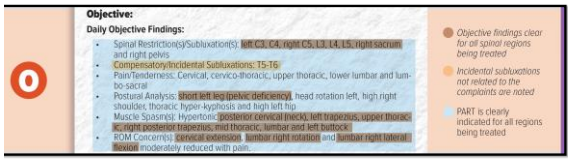
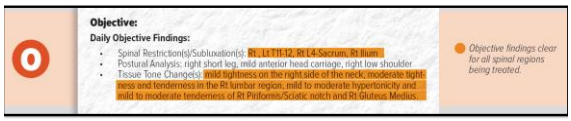
Active Treatment Routine Office Visit (ROV) Objective



- 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

79

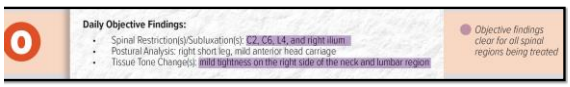
Preventive Maintenance Visit Objective



- 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

80

Wellness Visit Objective



- 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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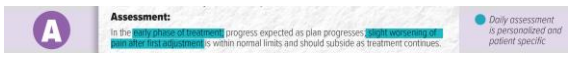
Active Treatment Routine Office Visit (ROV) Assessment



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

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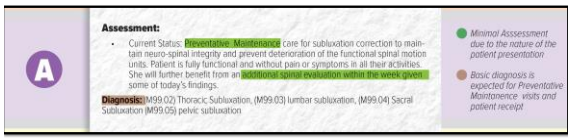
Preventive Maintenance Visit Assessment



- 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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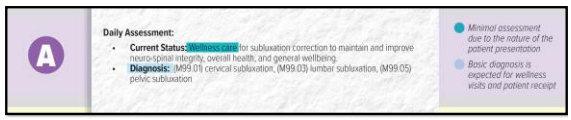
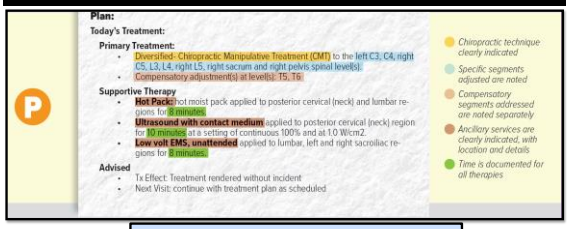
Wellness Visit Assessment



- 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

84

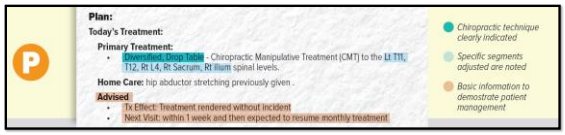
Active Treatment Routine Office Visit (ROV) Plan



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

85

Preventive Maintenance Visit Plan



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

86

Wellness Visit Plan

- 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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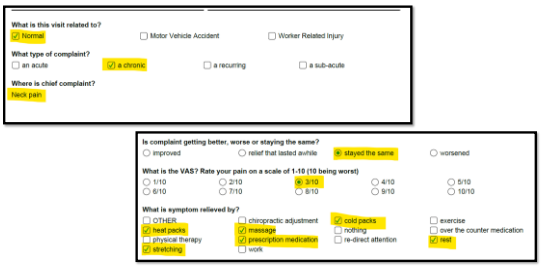
Initial Date of Service: 6/9/23



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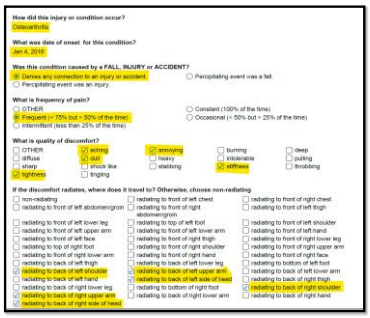

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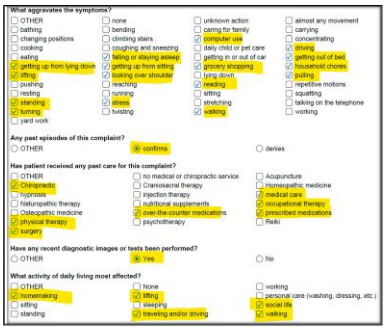

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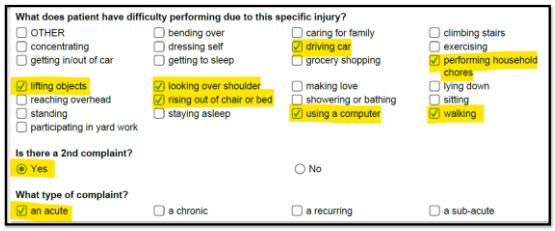

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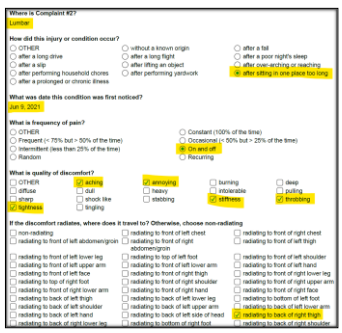

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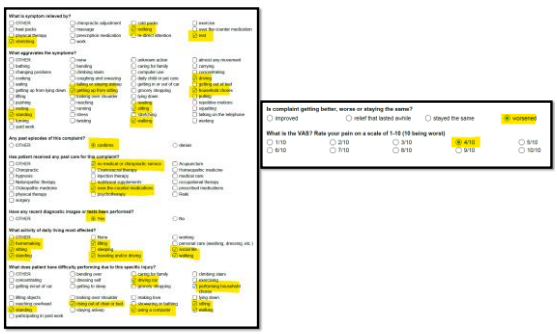

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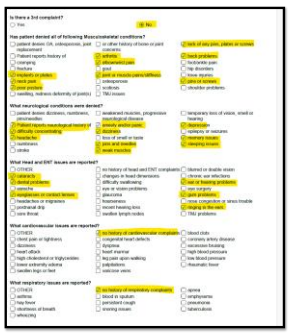

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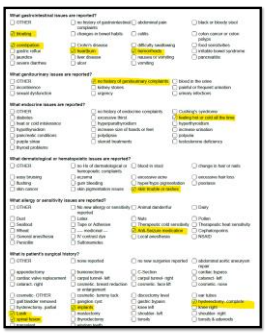

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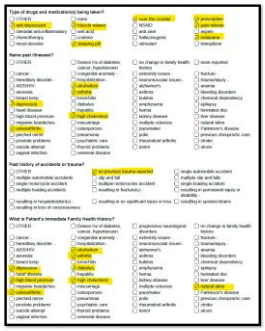

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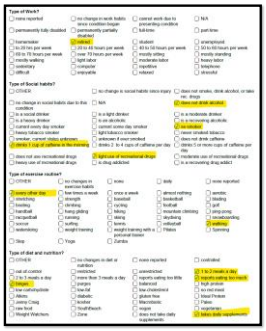

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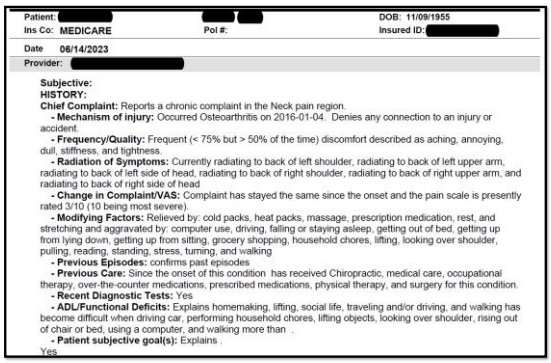

Patient: [redacted] DOB: 11/09/1955
Ins Co: MEDICARE Pol #: Insured ID: [redacted]
Date 06/14/2023
Provider: [redacted]

Subjective:
HISTORY:
Chief Complaint: Reports a chronic complaint in the Neck pain region.
- **Mechanism of injury:** Occurred Osteoarthritis on 2016-01-04. Denies any connection to an injury or accident.
- **Frequency/Quality:** Frequent (< 75% but > 50% of the time) discomfort described as aching, annoying, dull, stiffness, and tightness.
- **Radiation of Symptoms:** Currently radiating to back of left shoulder, radiating to back of left upper arm, radiating to back of left side of head, radiating to back of right shoulder, radiating to back of right upper arm, and radiating to back of right side of head.
- **Change in Complaint/VAS:** Complaint has stayed the same since the onset and the pain scale is presently rated 3/10 (10 being most severe).
- **Modifying Factors:** Relieved by: cold packs, heat packs, massage, prescription medication, rest, and stretching and aggravated by: computer use, driving, falling or staying asleep, getting out of bed, getting up from lying down, getting up from sitting, grocery shopping, household chores, lifting, looking over shoulder, pulling, reading, standing, stress, turning, and walking.
- **Previous Episodes:** confirms past episodes
- **Previous Care:** Since the onset of this condition has received Chiropractic, medical care, occupational therapy, over-the-counter medications, prescribed medications, physical therapy, and surgery for this condition.
- **Recent Diagnostic Tests:** Yes
- **ADL/Functional Deficits:** Explains homemaking, lifting, social life, traveling and/or driving, and walking has become difficult when driving car, performing household chores, lifting objects, looking over shoulder, rising out of chair or bed, using a computer, and walking more than .
- **Patient subjective goal(s):** Explains .

Yes

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Complaint #2: Reports an acute complaint in the Lumbar region.
- **Mechanism of injury:** Occurred after sitting in one place too long on 2021-06-09.
- **Frequency/Quality:** On and off discomfort described as aching, annoying, stiffness, throbbing, and tightness.
- **Radiation of Symptoms:** Currently radiating to back of right thigh
- **Change in Complaint/VAS:** Complaint has worsened since the onset and the pain scale is presently rated 4/10 (10 being most severe).
- **Modifying Factors:** Relieved by: nothing, rest, and stretching and aggravated by: driving, getting up from sitting, household chores, sitting, standing, and walking
- **Previous Episodes:** confirms past episodes
- **Previous Care:** Since the onset of this condition received no medical or chiropractic service and over-the-counter medications for this condition.
- **Recent Diagnostic Tests:** Yes
- **ADL/Functional Deficits:** Explains homemaking, lifting, sitting, social life, standing, traveling and/or driving, and walking has become difficult when driving car, performing household chores, rising out of chair or bed, sitting, standing, using a computer, and walking when does this for more than .

No

Systems Review: [redacted] reports status of condition(s) below which may relate to complaint(s):

- **Musculoskeletal:** Other than presenting musculoskeletal complaints, lack of any pins, plates or screws, arthritis, back problems, elbow/wrist pain, implants or plates, joint or muscle pains/stiffness, neck pain, pins or

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screws, and poor posture.
- **Neurological:** Other than presenting complaints, Patient reports neurological history of, anxiety and/or panic, depression, difficulty concentrating, dizziness, headache, memory issues, pins and needles, sleeping issues, and weak muscles.
- **Head & ENT:** Reports cataracts, dental problems, ear or hearing problems, eyeglasses or contact lenses, gum problems, and ringing in the ears
- **Cardiovascular:** Reports no history of cardiovascular complaints
- **Respiratory:** Reports no history of respiratory complaints
- **Gastrointestinal:** Reports bloating, constipation, heartburn, and hemorrhoids
- **Genitourinary:** Reports no history of genitourinary complaints
- **Endocrine:** Reports feeling hot or cold all the time
- **Derma./Hemo:** Reports skin trouble or rashes
- **Allergy/Sensitivity:** Reports Anti-Seizure medication

Past, Family and Social History:

- **Past Health History:**
  - **Surgery:** hysterectomy- complete, implants, Lasik, and cervical spinal fusion bilateral thumb surgery
  - **Medications:** over-the-counter, prescription, anti-depressant, muscle relaxer, pain reliever, marijuana, and sleeping pill
  - **Illnesses:** alcoholism, arthritis, depression, high cholesterol, and osteoarthritis
  - **Accidents:** no previous trauma reported
- **Family and Social History:**
  - **Family History:** alcoholism, arthritis, depression, diabetes, high blood pressure, high cholesterol, natural labor, and osteoarthritis
  - **Employment Status:** retired
  - **Social Habits:** does not drink alcohol, ex-smoker, drinks 1 cup of caffeine in the morning, and light use of recreational drugs
  - **Exercise Habits:** every other day and walking
  - **Diet and Nutrition:** 1 to 2 meals a day, reports eating too much, binges, and takes daily supplements

- Patient Comments: Patient states she has dizziness upon movement: rolling, sitting, standing, lying on her back described as she is spinning not the room.

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-Flexion: 90/90 degrees without pain, stiffness or radiation
-Extension: 15/30 degrees light aching
-Left Lat. Flexion: 25/35 degrees without pain, stiffness or radiation
-Right Lat. Flexion: 25/35 degrees without pain, stiffness or radiation
-Left Rotation: 20/30 degrees without pain, stiffness or radiation
-Right Rotation: 20/30 degrees without pain, stiffness or radiation

Neuro-*Mental Status:* Evaluations performed and the patient was observed to be alert and oriented X 3 (person place time) and cooperative .
Neuro-*Sensory-Pain:* Evaluations performed bilaterally. Dermatomal normal findings at all upper & lower spinal segments .
Neuro-*Gross Touch/Vibration:* Evaluations performed and indicated gross touch and vibration sensations were within normal limits at all upper & lower spinal segments .
Neuro-*Light Touch:* Evaluations performed and indicated [illegible] upper & lower spinal segments .
Neuro-*Deep Tendon Reflexes* (normal 2+):
- *Biceps:* Left 2+, Right 2+,
- *Triceps:* Left 2+, Right 2+,
- *Brachioradialis:* Left 2+, Right 2+,
- *Patellar:* Left 2+, Right 2+,
- *Achilles:* Left 2+, Right 2+.

Neuro-*Upper extremity resistive isometric motor testing* (normal 5/5):
- Shoulder Elevation: Left: 5 / 5 Right: 5 / 5
- Deltoid: Left: 5 / 5 Right: 5 / 5
- Biceps: Left: 5 /5 Right: 5 / 5
- Triceps: Left: 5 / 5 Right: 5 / 5
- Wrist Flexors: Left: 5 / 5 Right: 5 / 5
- Wrist Extensors: Left: 5 / 5 Right: 5 / 5
- Finger Extensors: Left: 5 / 5 Right: 5 / 5
- Finger Flexors: Left: 5 / 5 Right: 5 / 5
- Finger Abductors: Left: 5 / 5 Right: 5 / 5
- Palmar Interossei: Left: 5 / 5 Right: 5 / 5

Neuro-*Lower extremity resistive isometric motor testing* (normal 5/5):
- Iliopsoas: Left: 5 / 5 Right: 5 / 5
- Quadriceps: Left: 5 / 5 Right: 5 / 5
- Anterior Tibialis: Left: 5 / 5 Right: 5 / 5
- Hallucis Longus: Left: 5 / 5 Right: 5 / 5
- Ext Digitorum Longus & Brevis: Left: 5 / 5 Right: 5 / 5
- Gluteus Medius: Left: 5 / 5 Right: 5 / 5

Ortho-*Maximum Foramina Compression* performed. Patient indicated no pain.
Ortho-*Valsalva's* Maneuver performed. Patient indicated no pain.
Ortho-*Straight Leg Raiser Test* performed. Patient indicated no pain bilaterally.
Ortho-*FABERE/Patrick's Test* performed. Patient indicated no pain bilaterally.

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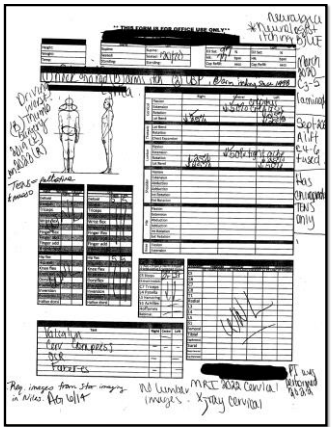

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Daily Objective Findings:

- *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:
ASSESSMENT:
[redacted] 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 [redacted] with: (M50.23) Other cervical disc displacement, cervicothoracic region, (M99.01) 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 [redacted] the recommended treatment/schedule, options, relative risks, and financial obligations. All questions were addressed and [redacted] expressed an understanding. At this time, an Informed Consent was signed and treatment begins today.
TREATMENT PLAN:
[redacted] 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 to18 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 Niles

105

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	CODING/ POLICY
General Considerations				
1. Is the provider's signature correctly added to the note? If yes, is it contemporaneous? If no, is there an attestation?	○		○	
2. Is the documentation legible enough to meet guidelines?	○		○	
3. Is the name of Beneficiary and date of service on all documentation?	○	○		
History				
4. Does the history of the Chief Complaint contain enough information to establish a cause for the visit (ie- mechanism of injury)?	○		○	
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)?	○	○		
6. Does history address the patient's past history with this problem, previous and/or similar episodes, treatments, and treatment outcomes?	○	○		
7.Does the history include measurable functional restrictions and/or functional deficits for each complaint?	○		○	
8. Does history include relevant ROS and PFSH necessary to rule in or out Complicating Factors and Red Flags to CMT or supportive therapies?	○	○		
9. Was an independent historian required or utilized for the intake of the history? And if so, was that documented?	○	○		
10. Does the history meet all the requirements as noted in the Part B Local Coverage Article (LCA) for the doctor's location?	○			○

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Examination				
11. Does the examination clinically correlate with the patient's documented complaints?	○		○	
12. Are Primary findings that are medically necessary separated from clinically appropriate Compensatory findings in the objective section?	○	○		
13. 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?	○	○		
14. 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?	○	○		
15. Were there X-rays ordered to be taken internally or by referral? If so, was the rationale, area(s) X-rayed, and radiology findings documented?	○			○
16. Is the Subluxation for each area treated demonstrated with either (A) 2 or more elements from PART (1 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)	○		○	
Assessment				
17. Is there an Assessment present that is not simply the Diagnosis?	○	○		
18. 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)? If MDM was used to select the E/M code?	○	○		
19. Are patient reporting, examination findings, Prognostic/Complicating Factors, Risk Factors, test results, and any unusual circumstances documented to substantiate care?	○	○		
20. Is the level of Medical Decision Making (MDM) clearly documented if MDM was used to select the E/M code?	○	○		
21. Does the Assessment address the existence of, or lack of, Red Flags (Indications / Contraindications) to the planned treatment?	○			○
22. 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?	○			○

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Audit Tool - Initial Visit - Page 2	YES/ N/A	IMPROVEMENT OPPORTUNITY	MEDICAL NECESSITY	CODING/ POLICY
Diagnosis (Dx)				
23. Do all areas of complaint that are going to be treated have a diagnosis?	○		○	
24. 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?	○		○	
25. If additional work-up or referral is ordered, is rationale and an acceptable preliminary or working diagnosis documented	○	○		
26. Are any non-musculoskeletal diagnosis codes reported on the 1500 claim form? If so, are they documented in the record?	○	○		
27.Are the diagnoses listed the highest degree of severity and/or specificity for the condition(s) reported and reviewed in history and examination?	○	○		
28. Are the Medicare diagnosis codes coupled with the Primary Subluxation code first and the Neuromusculoskeletal condition code as the Secondary Diagnosis code for each region being billed for active treatment?	○			○
Treatment Plan				
29. 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?	○		○	
30. Does the Initial Treatment Plan contain specific, measurable, and functional short-term and long-term treatment goals?	○		○	
31. Does the Initial Treatment Plan contain objective measures that can be used to evaluate treatment effectiveness from initial visit to each re-evaluation?	○		○	
32. Is the recommended CMT supplied with rationale, technique, and regions to be adjusted?	○		○	
33. Are the recommended therapies/modalities ordered, supplied with rationale for their use, location, and settings?	○		○	
34. If more-invasive, additional diagnostics, or DME are ordered, in-house or by referral (radiology, nerve studies, US, orthoses), is there justification (from history/exam/other testing or records, diagnoses) to support the order?	○		○	

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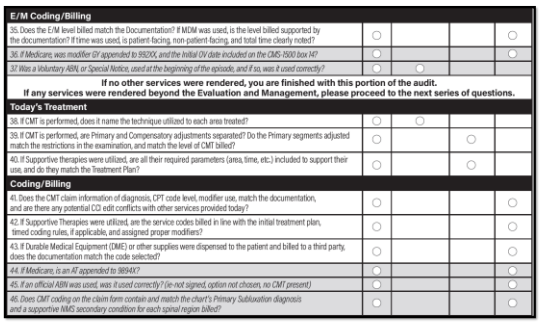

E/M Coding/Billing				
35. Does the E/M level billed match the Documentation? If MDM was used, is the level billed supported by the documentation? If time was used, is patient-facing, non-patient-facing, and total time clearly noted?	○			○
36. If Medicare, was modifier GY appended to 99200, and the Initial OV date included on the CMS-1500 box 14?	○			○
37. 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. **If any services were rendered beyond the Evaluation and Management, please proceed to the next series of questions.**				
Today's Treatment				
38. If CMT is performed, does it name the technique utilized to each area treated?	○	○		
39. 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?	○		○	
40. 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				
41. Does the CMT claim information of diagnosis, CPT code level, modifier use, match the documentation, and are there any potential CCI edit conflicts with other services provided today?	○			○
42. If Supportive Therapies were utilized, are the service codes billed in line with the initial treatment plan, timed coding rules, if applicable, and assigned proper modifiers?	○			○
43. 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?	○			○
44. If Medicare, is an AT appended to 98940?	○			○
45. If an official ABN was used, was it used correctly? (ie-not signed, option not chosen, no CMT present)	○			○
46. Does CMT coding on the claim form contain and match the chart's Primary Subluxation diagnosis and a supportive NMS secondary condition for each spinal region billed?	○			○

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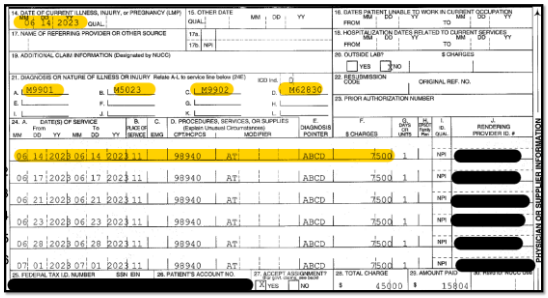

14. DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP)	15. OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD YY 06 14 2023 QUAL.	MM DD YY QUAL.	MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.
A. M9901 B. M5023 C. M9902 D. M6283 E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
06 14 2023	06 14 2023	11		98940	AT	ABCD	7500	1		NPI	
06 17 2023	06 17 2023	11		98940	AT	ABCD	7500	1		NPI	
06 21 2023	06 21 2023	11		98940	AT	ABCD	7500	1		NPI	
06 23 2023	06 23 2023	11		98940	AT	ABCD	7500	1		NPI	
06 28 2023	06 28 2023	11		98940	AT	ABCD	7500	1		NPI	
07 01 2023	07 01 2023	11		98940	AT	ABCD	7500	1		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ 45000	29. AMOUNT PAID $ 15804	30. Rsvd. NUCC Use

AMERICAN MEDICAL ASSOCIATION CMS-1500 (02-12) PLEASE PRINT OR TYPE FOR INFORMATION

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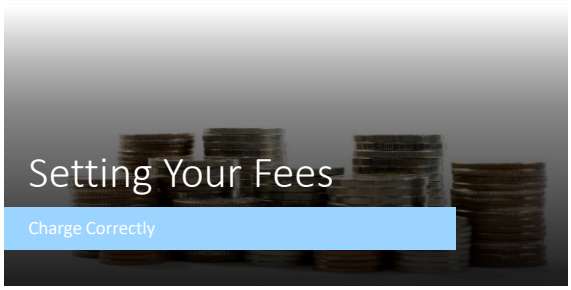
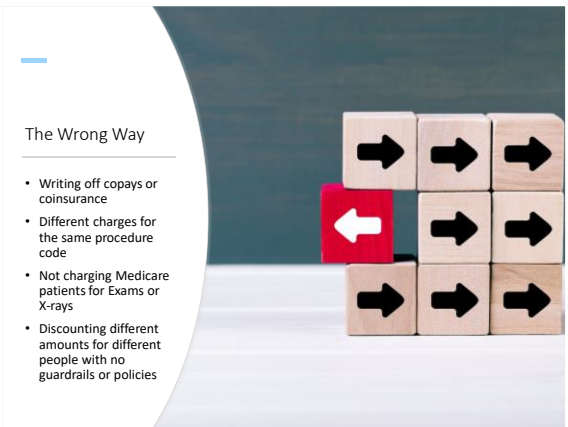


111

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

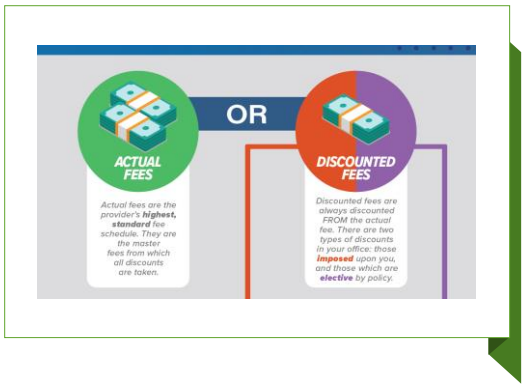


The Wrong Way

- Writing off copays or coinsurance
- Different charges for the same procedure code
- Not charging Medicare patients for Exams or X-rays
- Discounting different amounts for different people with no guardrails or policies

113

114



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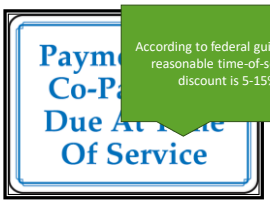
Compliant Time of Service Discounts



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

Discount is based on
bookkeeping
gs
ay or may not be
efined
ften not defensible
or unreasonable
- May not be permissible on Federally insured patients

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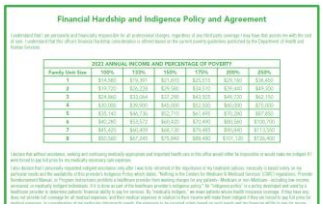
- An Established Sliding Fee Schedule
- Qualify and Verify Hardship
- Should be Requested
- Policy in Place

120

Clear & Defined Terms


Financial Hardship and Indigence Policy and Agreement

2023 ANNUAL INCOME AND PERCENTAGE OF POVERTY

Family Unit Size	100%	133%	150%	175%	200%	250%
1	$14,580	$19,391	$21,870	$25,515	$29,160	$36,450
2	$19,720	$26,228	$29,580	$34,510	$39,440	$49,300
3	$24,860	$33,064	$37,290	$43,505	$49,720	$62,150
4	$30,000	$39,900	$45,000	$52,500	$60,000	$75,000
5	$35,140	$46,736	$52,710	$61,495	$70,280	$87,850
6	$40,280	$53,572	$60,420	$70,490	$80,560	$100,700
7	$45,420	$60,409	$68,130	$79,485	$90,840	$113,550
8	$50,560	$67,245	$75,840	$88,480	$101,120	$126,400


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:

	100% of poverty or lower	101-133% of poverty	134-150% of poverty	151-175% of poverty	176-200% of poverty	201-250% of poverty
Percentage discount from actual fee, deductible, copay, or flat fee	$10 Flat Fee	$20 Flat Fee	$30 Flat Fee	$40 Flat Fee	$50 Flat Fee	$60 Flat Fee
	Exclusions: Does not apply to durable medical equipment, etc.	Exclusions: Does not apply to durable medical equipment, etc.	Exclusions: Does not apply to durable medical equipment, etc.	Exclusions: Does not apply to durable medical equipment, etc.	Exclusions: Does not apply to durable medical equipment, etc.	Exclusions: Does not apply to durable medical equipment, etc.

Patient name | Patient signature | Date signed

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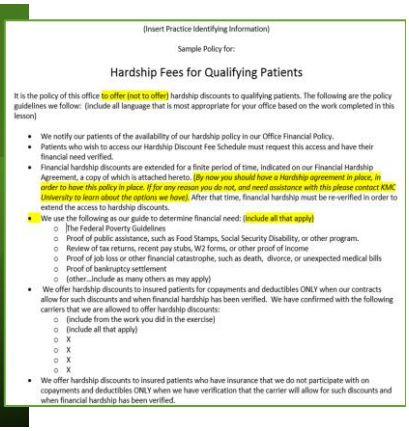
Hardship Internal Office Policy & Procedure


(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
  - (other…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.

122

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?

123

Legal & Safe Discounting

Membership in a DMPO al… a… n… p… th… n… to… uninsured, and partially insured patients (e.g., Medicare patients)

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

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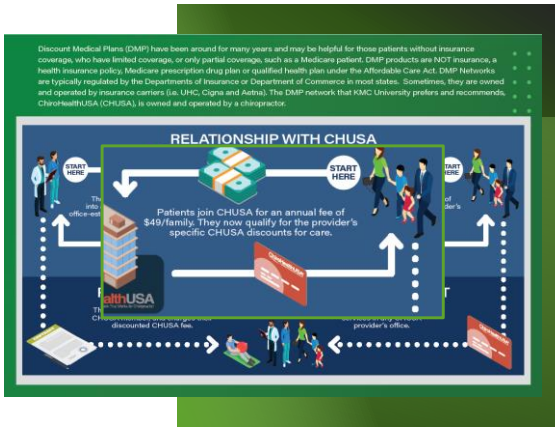

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Caution Danger!

- 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.**

127

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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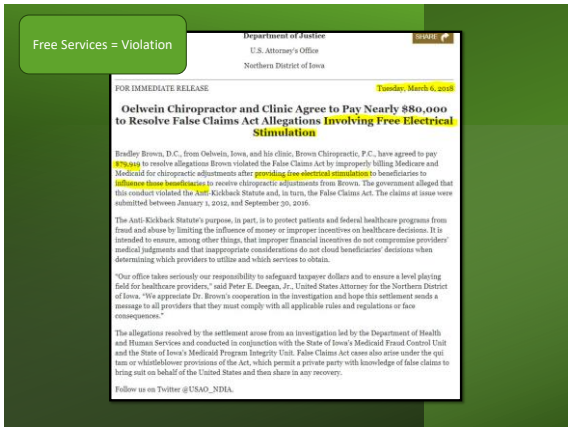
Inducement Violations

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.

129

Free Services = Violation



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

FOR IMMEDIATE RELEASE — Tuesday, March 6, 2018

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 $79,919 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 those 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, 2016.

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 providers 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. Deegan, 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 then share in any recovery.

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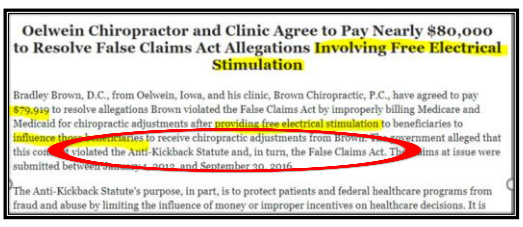
Costly Mistake
Not Knowing the Rules and No SOP



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131

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

132

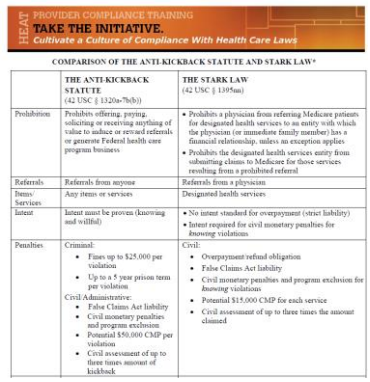
Dual Fee Schedules

Important to know what is and isn't a dual fee schedule

- Misrepresents charges to carriers
- False Claims Act violation
- May violate provider agreements

133

Don't Wing It! Seek Assistance



COMPARISON OF THE ANTI-KICKBACK STATUTE AND STARK LAW*

	THE ANTI-KICKBACK STATUTE (42 USC § 1320a-7b(b))	THE STARK LAW (42 USC § 1395nn)
Prohibition	Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business	• 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 • Prohibits the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral
Referrals	Referrals from anyone	Referrals from a physician
Items/ Services	Any items or services	Designated health services
Intent	Intent must be proven (knowing and willful)	• No intent standard for overpayment (strict liability) • Intent required for civil monetary penalties for knowing violations
Penalties	Criminal: • Fines up to $25,000 per violation • Up to a 5 year prison term per violation Civil Administrative: • False Claims Act liability • Civil monetary penalties and program exclusion • Potential $50,000 CMP per violation • Civil assessment of up to three times amount of kickback	Civil: • Overpayment/refund obligation • False Claims Act liability • Civil monetary penalties and program exclusion for knowing violations • Potential $15,000 CMP for each service • Civil assessment of up to three times the amount claimed

134

Out of Network Patients

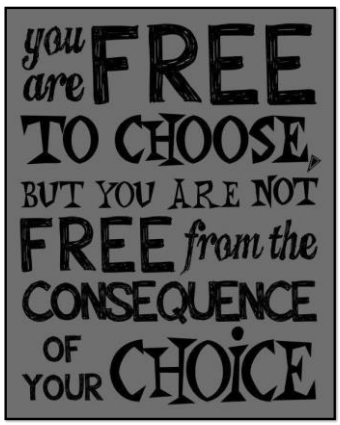
- If you represent full fee to the insurer, the patient must pay full fee
- What you bill is what you expect to collect, outside of any agreements/contracts
- Charge correctly, bill correctly, collect according to your office policy

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

136



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Risk Management Considerations- Patient Billing & Collections

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

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Objectives

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

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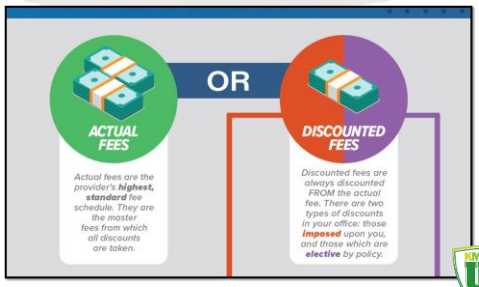
The Basics of Fees



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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.

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

your fees

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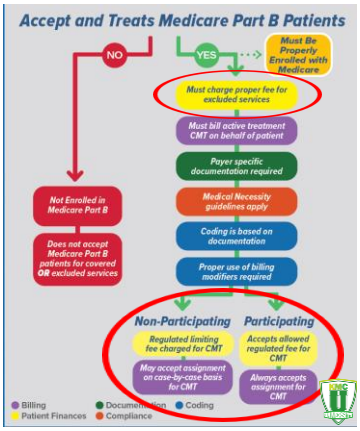
Your Obligation When Agreeing to Accept and Treat Medicare Part B Patients



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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

Begin Service Date	End Service Date	Rendering NPI	POS	Units	Procedure Code	Modifiers	Billed Amount	Allowed Amount	Deductible	Copay Coinsurance	Adjust Codes	Paid Provi	Remark Code
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	
020323	020323	1234567890	11	1	97035	GY, GP	30.00	0.00	0.00	0.00	PR	0.00	96 , N425

$ 307.46

CO Contractual Obligation
PR Patient Responsibility
45 Charge exceeds fee schedule/ maximum allowable
96 non-covered charges
N425 Statutorily Excluded service(s)

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

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MEDICARE MODIFIERS

Modifiers Used Only With 98940, 98941, 98942

Modifier	Description/Instruction	Effect on Medicare Payment
AT	Reporting Active/Corrective Treatment Indicates service rendered was medically necessary per Medicare guideline	Medicare will consider for payment.
GA	Waiver of Liability (ABN) on file for mandatory use Indicates maintenance care or visits exceed carrier screen	If patient selects ABN Option 1, you must bill Medicare. Medicare will deny as not medically necessary. Patient will be financially responsible.
GZ	Indicates you failed to collect ABN 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	ABN on file for voluntary use	Claim will be denied/patient financially liable; we don't recommend Medicare's official ABN 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

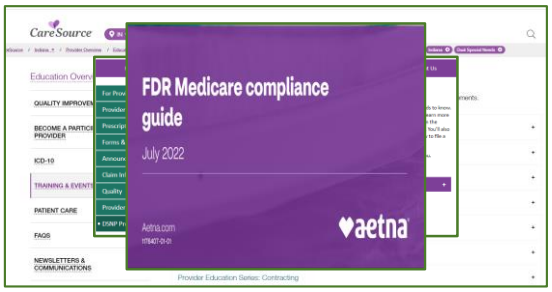
In Network Doctors

- 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



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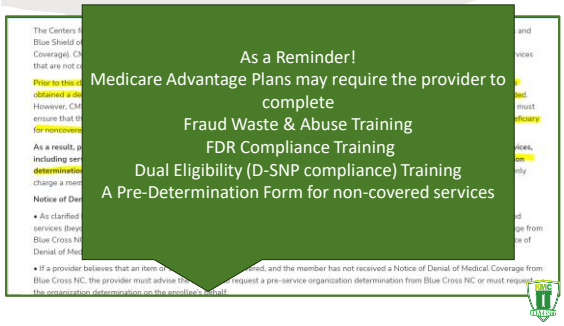
The Pre-Service Determination Requirement for MA Plans



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?

156

The Compliant Way..

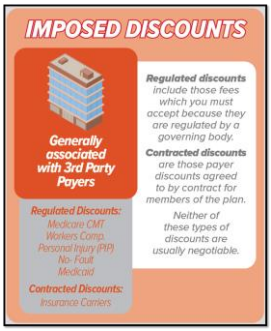
For Non-Covered or Excluded Services…

- 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

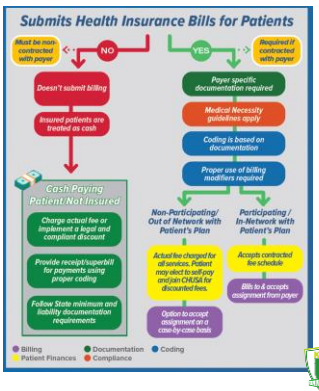
Insured Patients & Imposed Discounts

- 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



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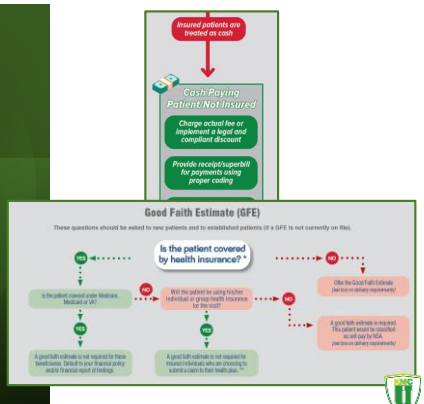
The Out of Network Doctor Who Does NOT Submit Claims



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
Judy Jones 04-02-1997

Estimate

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Exam (Evaluation)	low back, shoulder, neck, midback		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 bubble if not scheduled

Estimate

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Exam (Evaluation)	low back, shoulder, neck, midback		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

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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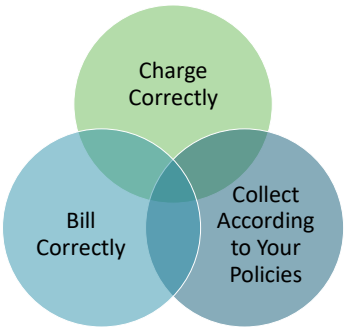
Key to All Finances



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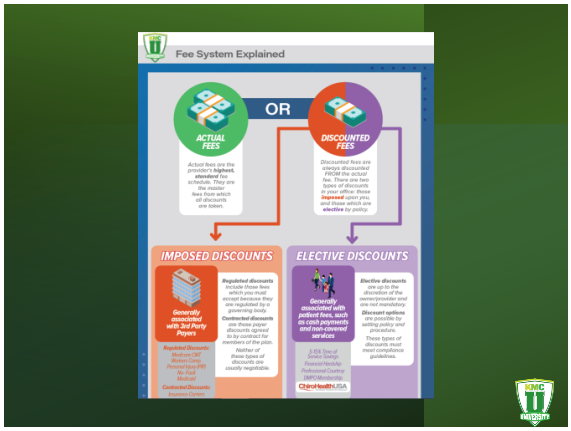

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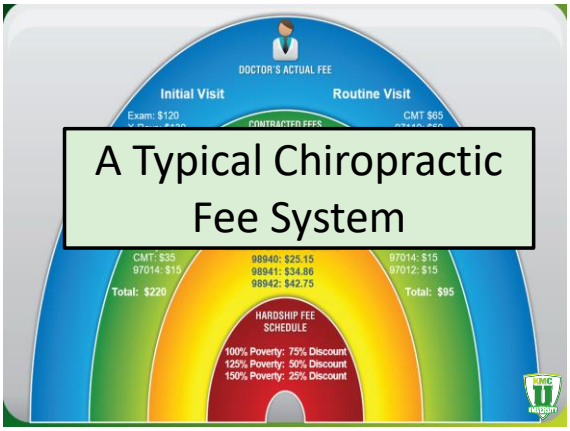

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Know All Your Imposed Discounts

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

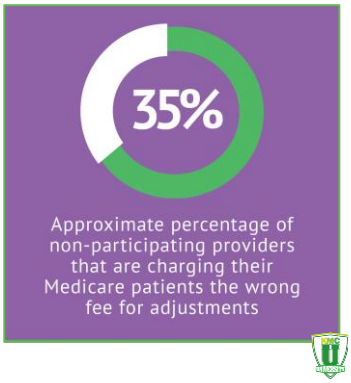
178

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

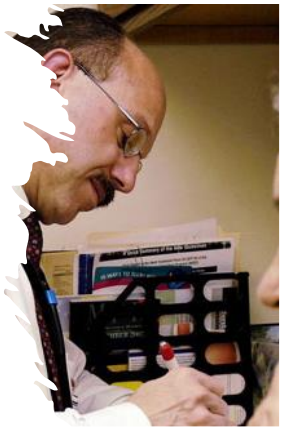
Medicare Non-Par Doesn't Mean Wild West!



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



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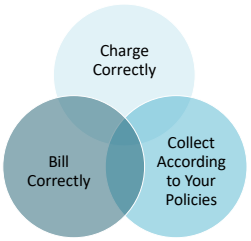
Medicare Billing Requirements

- 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 c
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 pa
ical research
o get details of Treatment co
o expect continuity of Car
o obtain Second opinic

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

183

Elective Discounts the Compliant Way

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

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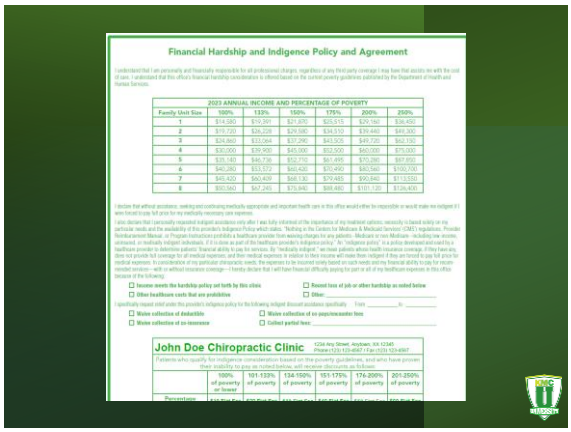

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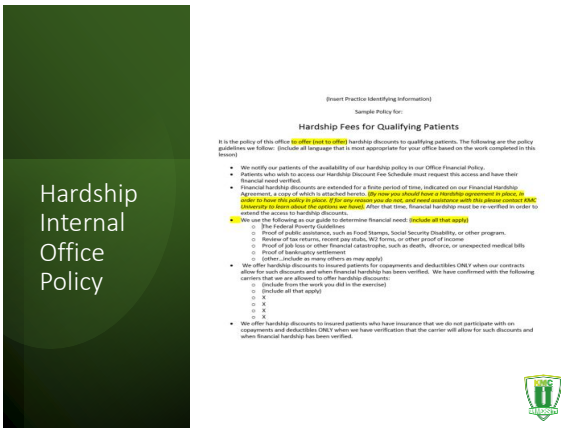

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Professional Courtesy Office Policy

- 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.

193

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

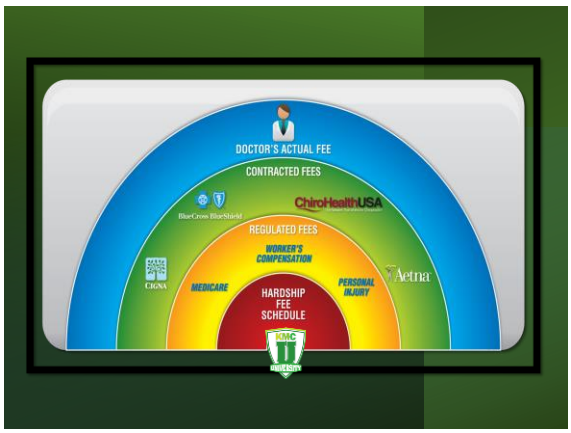
194

195

Legal & Safe Discounting

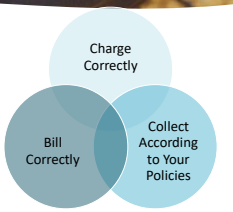
Membership in a DMPO allows you to bill your actual fees when necessary and offers the protection of a contract that allows you to offer network-based discounts to your cash, underinsured, and partially insured patients (e.g., Medicare patients)

196



197

Collect According to Your Policies



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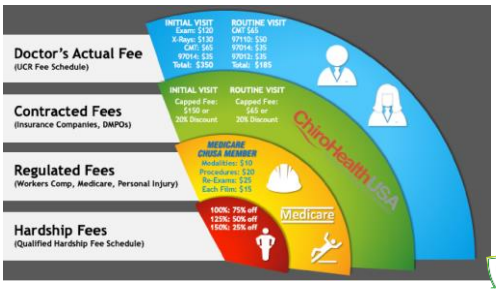
Collecting Money for Services

How you collect money for services can be problematic for compliance

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

199

Patient Responsibility



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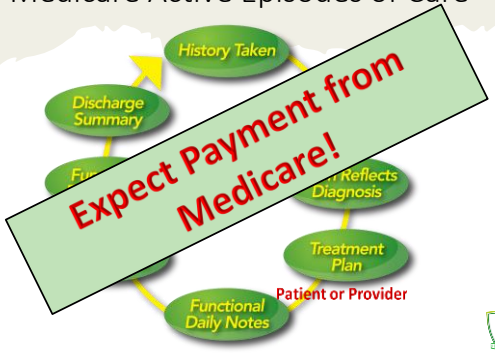
Medicare Active Episodes of Care



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

- Wellness
  - Prevent di
  - Pro
  - of life
  - tive
  - Maintain or prevent deterioration of a chronic condition

Expect Payment from Your Patient!

203

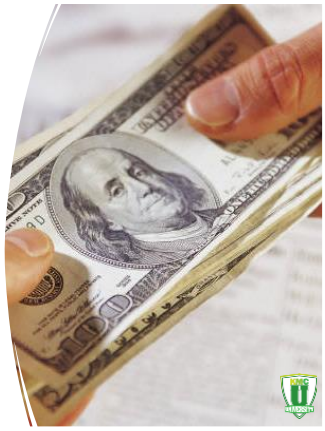
Three Choices for Fees in Maintenance Care

- 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 3rd party
- Automatic payments from credit card handled properly
- No discounts given on 3rd 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.

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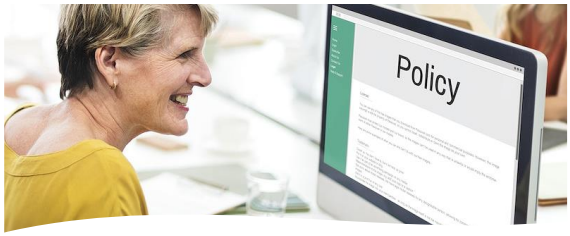


A Public Financial Policy

- 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 ha… $40.00 for M… bill
  - …jury patien…
  - …tients $130.0…
  - …e have a… …ient, no …urance se… …e of $65…
  - …m, X-ray and… …nt…
  - …r long-term pa… …ay …rate of $25…
  - ad… …pay $35.00…

215

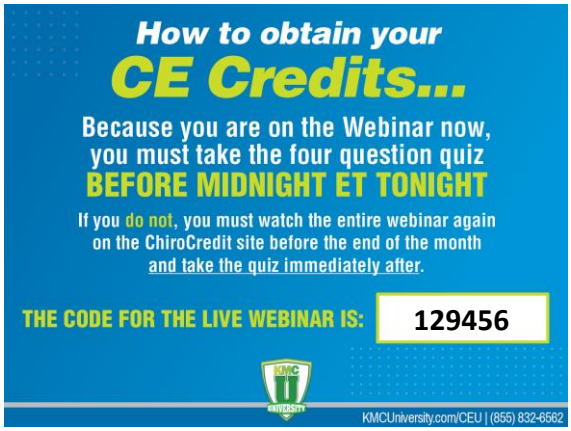
Patient Financial Compliance is Not Optional

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



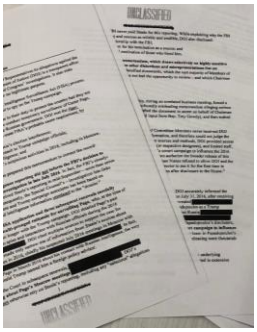
218

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

221

What Can You Say?

222

Make Statements Not Discussions

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

223

Establish a Process

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

224

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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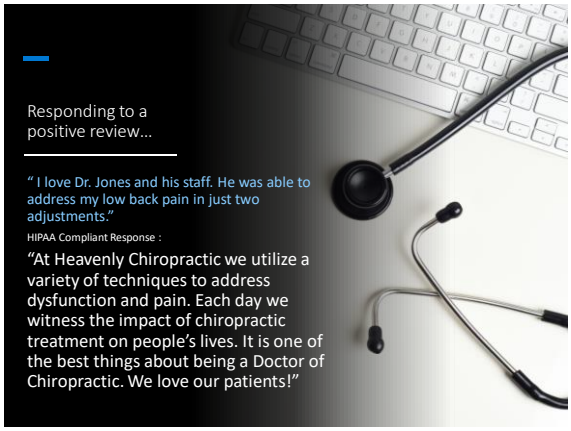

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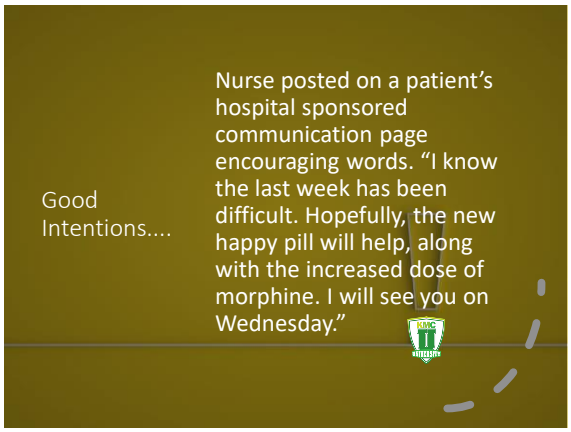

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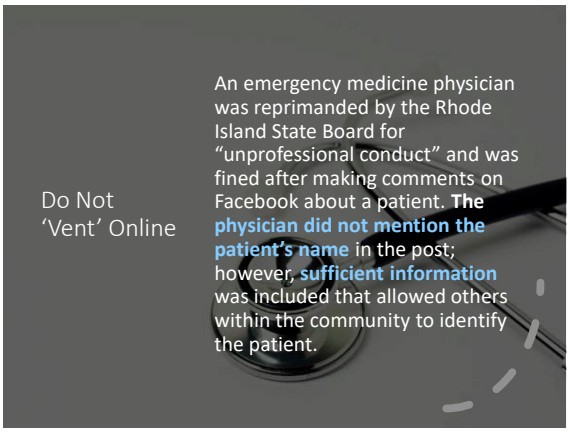

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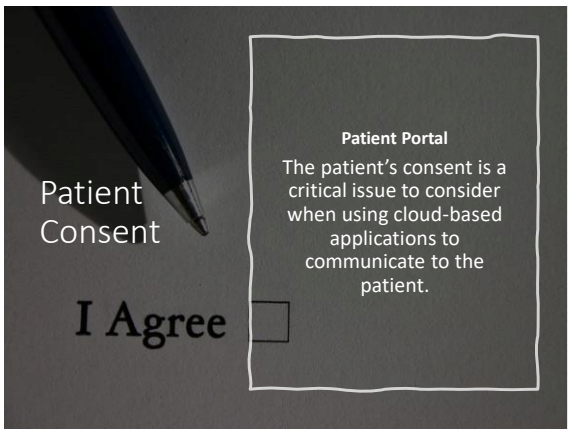

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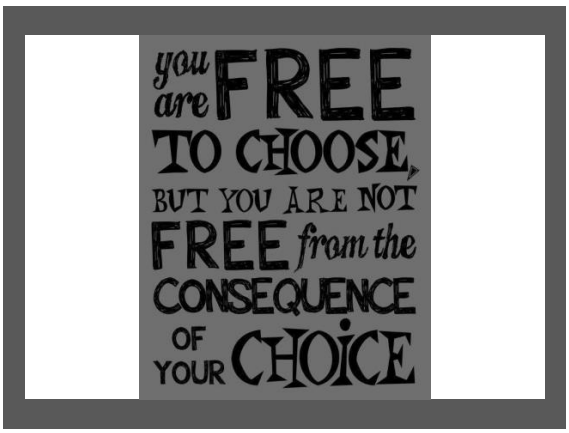

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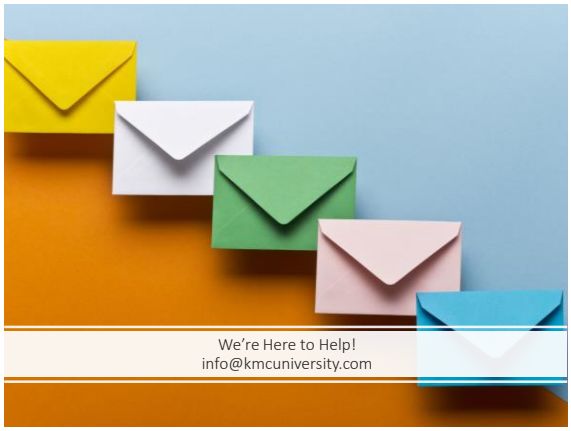
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