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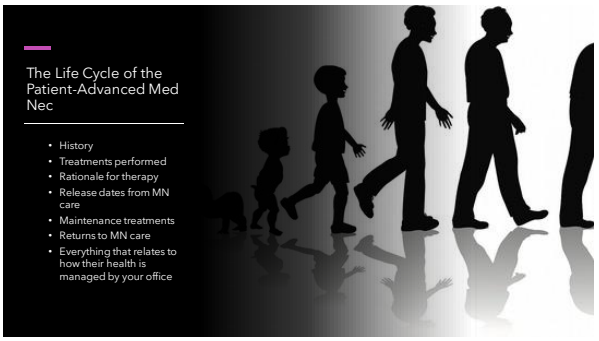

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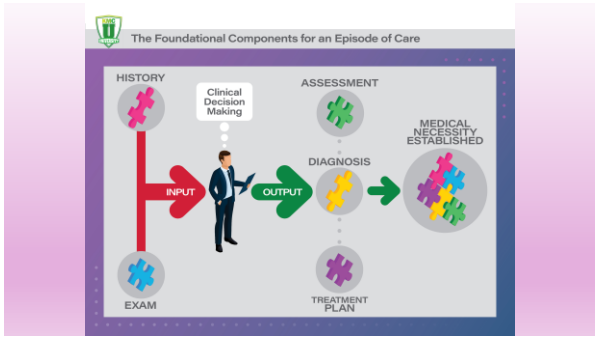
What Medicare Payers Want to See

- Prove Medical Necessity
- Cause and start date
- End date of care
- Diagnosis match patient complaints, does that match billing and coding
- Is patient on/following a treatment plan?

3

Your Patient's Flow Under Care

4



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Medicare Documentation Guidelines in the Absence of Others

Initial Visit
History
Description of Present Illness
Physical Exam
Diagnosis
Treatment Plan
Date of initial treatment

Subsequent Visits
History
Review of chief complaint
Physical Exam
Document daily treatment
Progress related to treatment goals/plan

6

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.

7

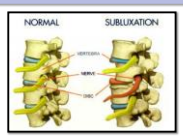
AT = Active Treatment

- By definition meets medical necessity
- Billed and expected to be paid
- Follows MAC screens
- Should not be automatic

8

The Opposite of Active Treatment

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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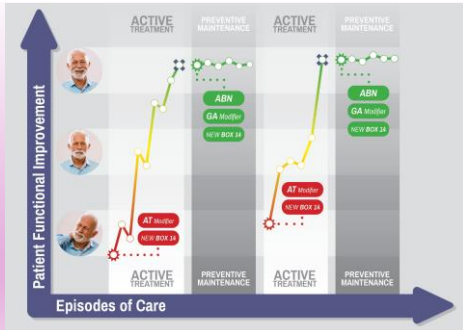

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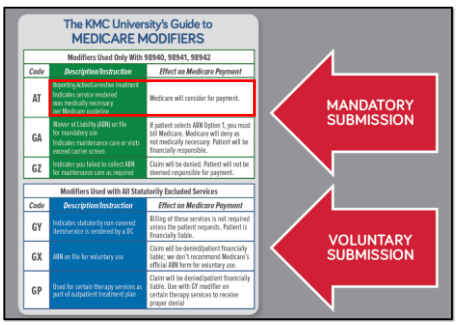

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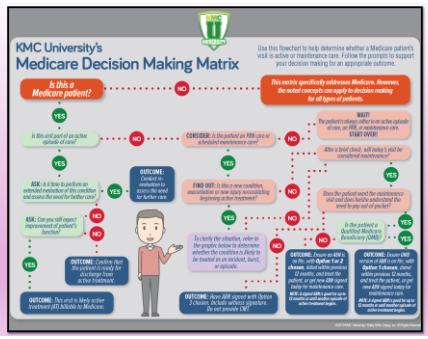

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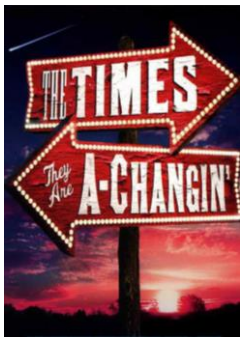
Let's be clear:

- None of this is new
- Compliance is been around for decades
- The difference now, is auditors, insurance companies and the government are bothering to look!
- Now for some "Risk Management"



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13

Your Passion is Also a Regulated Business

14

Parts of an Effective Office Compliance Program

- CMS/Medicare
- OIG compliance
- HIPAA
- OSHA
- CLIA
- Anti-Kickback Laws
- Stark Laws
- State laws
- Employment Laws

15

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.

16

Government's Healthcare Oversight

HHS OIG is the largest inspector general's office in the Federal Government, with approximately 1,600 dedicated to combating fraud, waste and abuse and to improving the efficiency of HHS programs

A majority of OIG's resources goes toward the oversight of Medicare and Medicaid — programs that represent a significant part of the Federal budget and that affect this country's most vulnerable citizens

17

Federal Register Vol. 81, No. 29 February 12, 2016

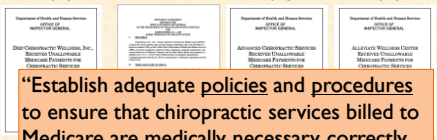
(pg. 7661) We believe that undertaking no or minimal compliance activities to monitor the accuracy and appropriateness of a provider or supplier's Medicare claims would expose a provider or supplier to liability under the identified standard articulated in this rule based on the failure to exercise reasonable diligence if the provider or supplier received an overpayment.

We also recognize that compliance programs are not uniform in size and scope and that compliance activities in a smaller setting, such as a solo practitioner's office, may look very different than those in larger setting, such as a multi-specialty group.

18

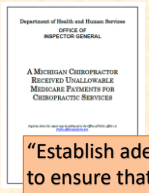
Outliers Audited & Made Example

2013 2014 2015 2015



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

19



AUGUST 2016

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

20

What An OIG Compliance Program IS

21

Compliance Program Purpose

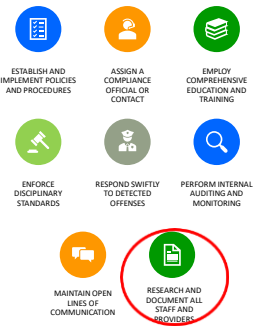
Integrate policies and procedures into the physician's practice that are necessary to promote adherence to federal and state laws and statutes and regulations applicable to the delivery of healthcare services

22

OIG Recommends Policies and Procedures to Address THESE Risks

23

Elements of an OIG Compliance Program



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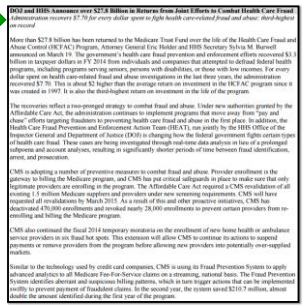
March 2015



DOJ and HHS Announce over $27.8 Billion in Returns from Joint Efforts to Combat Health Care Fraud

Administration recovers $7.70 for every dollar spent to fight health care-related fraud and abuse; third-highest on record

More than $27.8 billion has been returned to the Medicare Trust Fund over the life of the Health Care Fraud and Abuse Control (HCFAC) Program, Attorney General Eric Holder and HHS Secretary Sylvia M. Burwell announced on March 19. The government's health care fraud prevention and enforcement efforts recovered $3.3 billion in taxpayer dollars in FY 2014 from individuals and companies that attempted to defraud federal health programs, including programs serving seniors, persons with disabilities, or those with low incomes. For every dollar spent on health care-related fraud and abuse investigations in the last three years, the administration recovered $7.70. This is about $2 higher than the average return on investment in the HCFAC program since it was created in 1997. It is also the third-highest return on investment in the life of the program.

The recoveries reflect a two-pronged strategy to combat fraud and abuse. Under new authorities granted by the Affordable Care Act, the administration continues to implement programs that move away from "pay and chase" efforts targeting fraudsters to preventing health care fraud and abuse in the first place. In addition, the Health Care Fraud Prevention and Enforcement Action Team (HEAT), run jointly by the HHS Office of the Inspector General and Department of Justice (DOJ) is changing how the federal government fights certain types of health care fraud. These cases are being investigated through real-time data analysis or lists of a prolonged subpoena and account analyses, resulting in significantly shorter periods of time between fraud identification, arrest, and prosecution.

CMS is adopting a number of preventive measures to combat fraud and abuse. Provider enrollment is the gateway to billing the Medicare program, and CMS has put critical safeguards in place to make sure that only legitimate providers are enrolling in the program. The Affordable Care Act required a CMS revalidation of all existing 1.5 million Medicare suppliers and providers under new screening requirements. CMS will have requested all revalidations by March 2015. As a result of this and other proactive initiatives, CMS has deactivated 470,000 enrollments and revoked nearly 28,000 enrollments to prevent certain providers from re-enrolling and billing the Medicare program.

CMS also continued the fiscal 2014 temporary moratoria on the enrollment of new home health or ambulance service providers in six fraud hot spots. This extension will allow CMS to continue its actions to suspend payments or remove providers from the program before allowing new providers into potentially over-supplied markets.

Similar to the technology used by credit card companies, CMS is using its Fraud Prevention System to apply advanced analytics to all Medicare Fee-For-Service claims on a streaming, national basis. The Fraud Prevention System identifies aberrant and suspicious billing patterns, which in turn trigger actions that can be implemented swiftly to prevent payment of fraudulent claims. In the second year, the system saved $210.7 million, almost double the amount identified during the first year of the program.

25

26

27

A "Program" is Not a "Manual"

28

29

KMC's "Either/Or" Principle
Traditional Part B Medicare

Either enrolled with Medicare or don't see Medicare Patients
Either covered service or statutorily excluded service
Either Medicare responsible or patient responsible
Either active treatment or maintenance care
Either mandatory ABN or voluntary ABN
CMT is either AT or GA

Never S8990 with Traditional Part B Medicare

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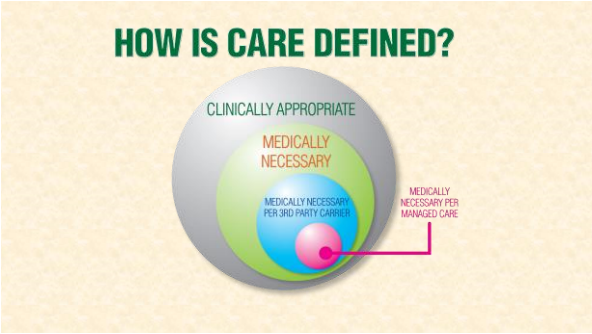

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Is All Care Medically Necessary?

Clinically Appropriate Care

- Maintenance care
- Supportive care
- Palliative care
- Life enhancing and wellness care
- Symptom relieving only
- Care that doesn't have as its goal improved function and correction
- All care within your scope of practice, because Doctor is your first name

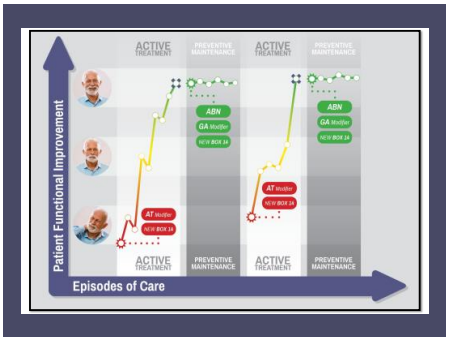
Medically Necessary Care

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

32

Medical Necessity = Coverage parameters set and defined by third-party payers

33



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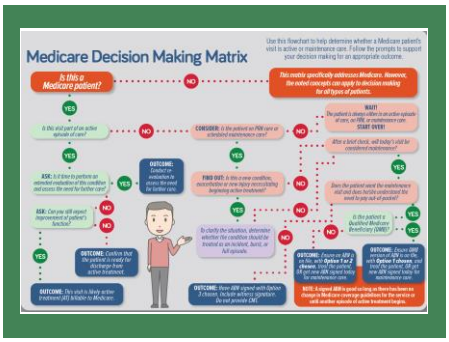

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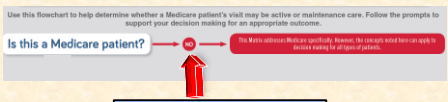
Not Medicare Only…



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

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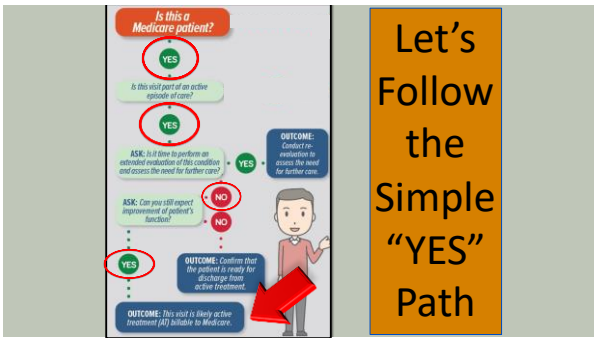

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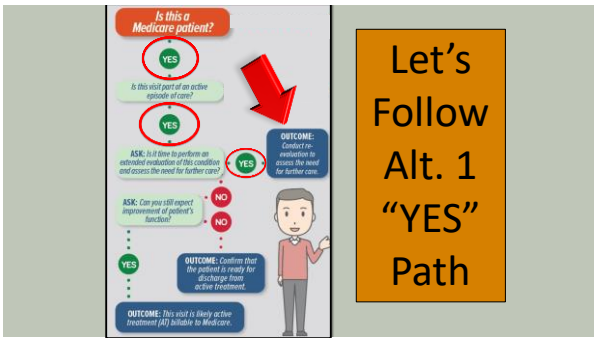

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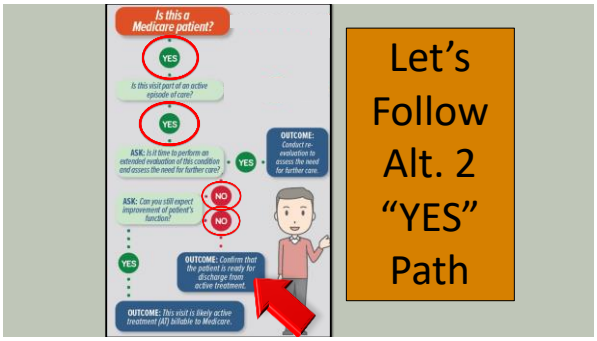

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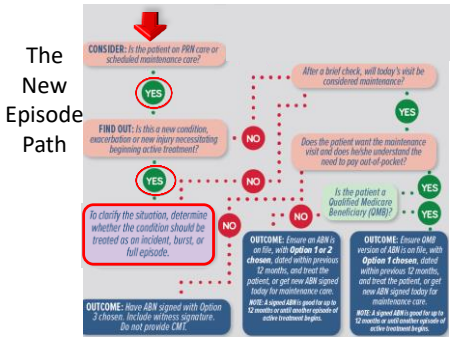

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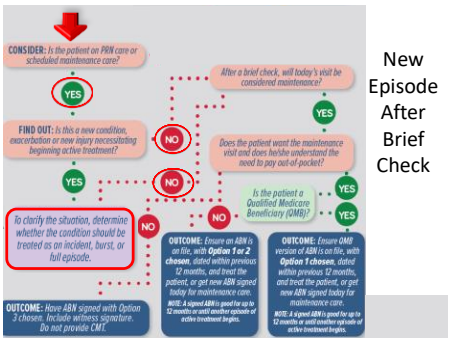

New Episode After Brief Check

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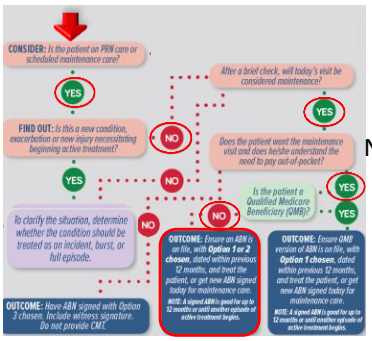

The True Non-AT Path Non-QMB

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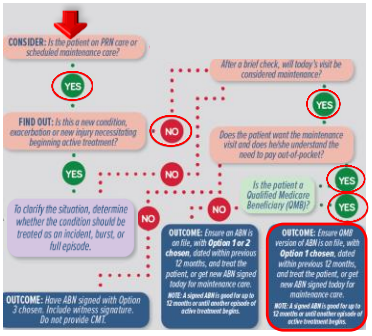

The True Non-AT Path For a QMB

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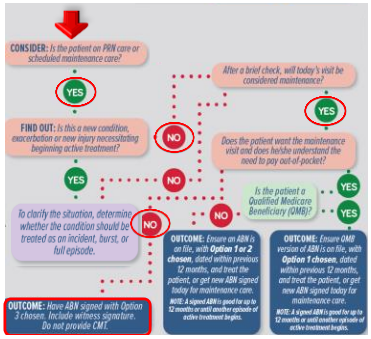

The Non-AT Path "No Thank You"

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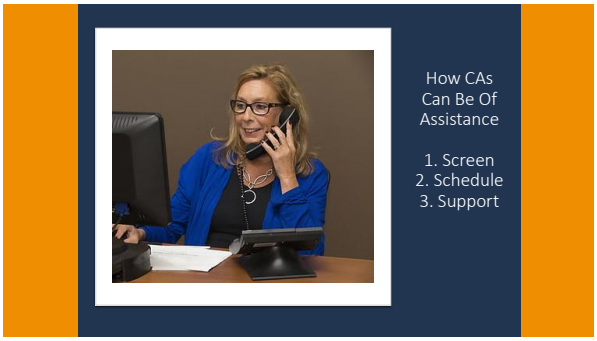

How CAs Can Be Of Assistance

1. Screen
2. Schedule
3. Support

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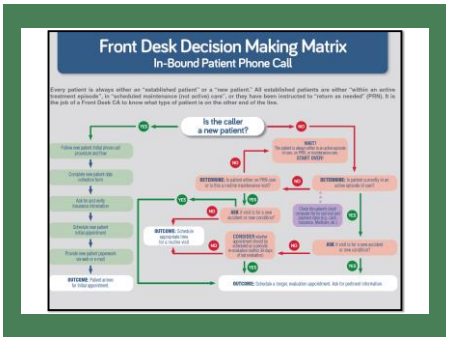

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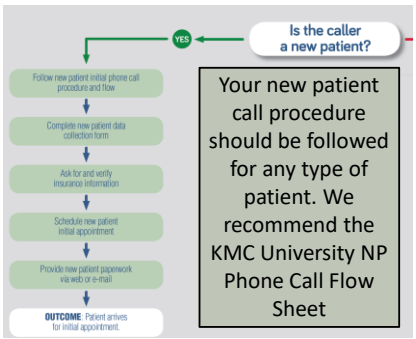

Your new patient call procedure should be followed for any type of patient. We recommend the KMC University NP Phone Call Flow Sheet

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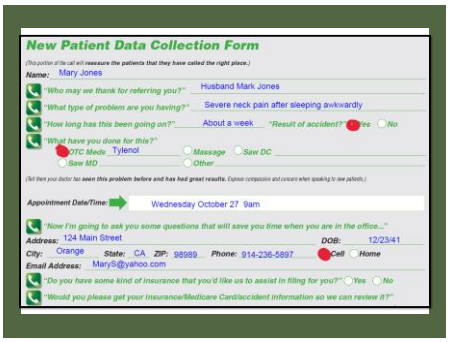

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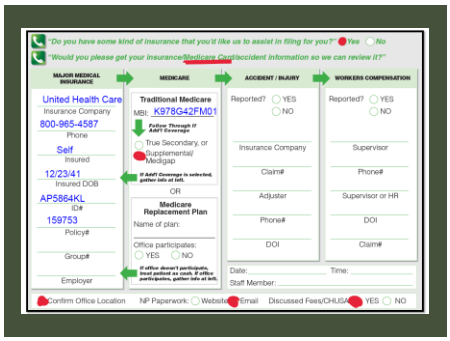

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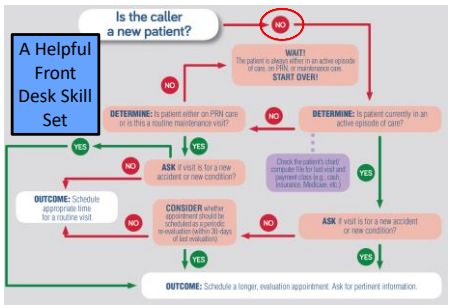

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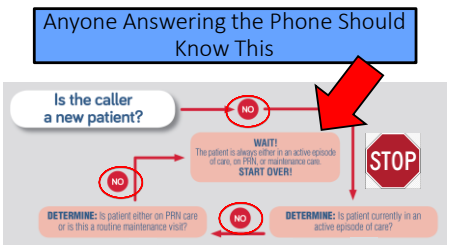

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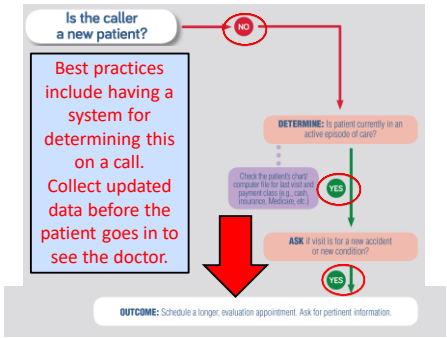

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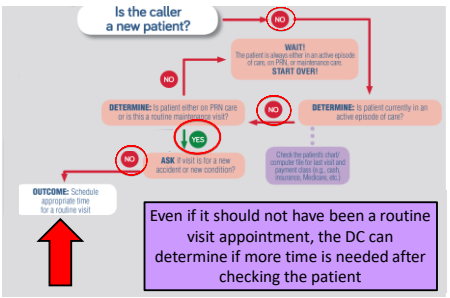

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Open Forum for Questions and Issues

54

You Don't Have to KNOW All the Answers…

- Follow Official Coding Rules and Guidelines
- Have *current* coding resources available
- Rely on a certified coding specialist when you have questions, not your buddy!
- Ongoing training is essential and your obligation!

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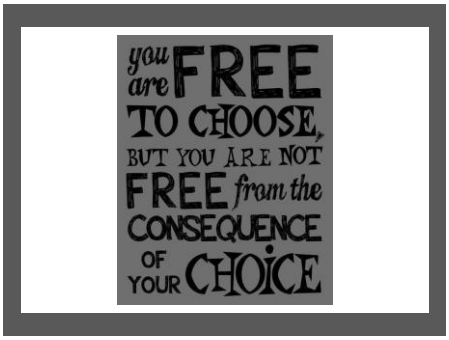

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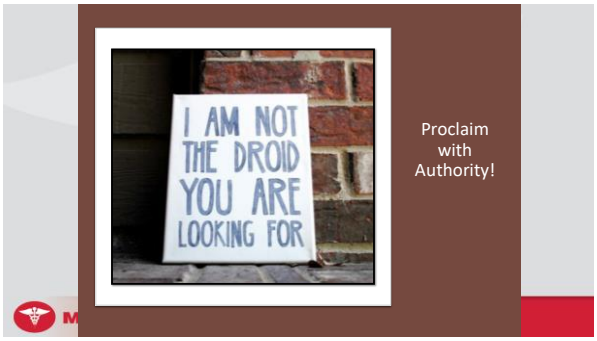

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