

Be Brilliant in Your Office: The Key to Higher Reimbursement and Lower Risk  
 Part 4: Tying the Revenue Cycle Together-Compliantly

**RISK**

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The Life Cycle of the Patient-Advanced Med Nec

- History
- Treatments performed
- Rationale for therapy
- Release dates from MN care
- Maintenance treatments
- Returns to MN care
- Everything that relates to how their health is managed by your office

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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

The Foundational Components for an Episode of Care

**HISTORY** (Clinical Decision Making)

**ASSESSMENT**

**DIAGNOSIS**

**TREATMENT PLAN**

**MEDICAL NECESSITY ESTABLISHED**

INPUT → OUTPUT

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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

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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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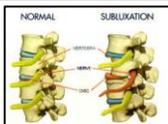
AT = Active Treatment

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

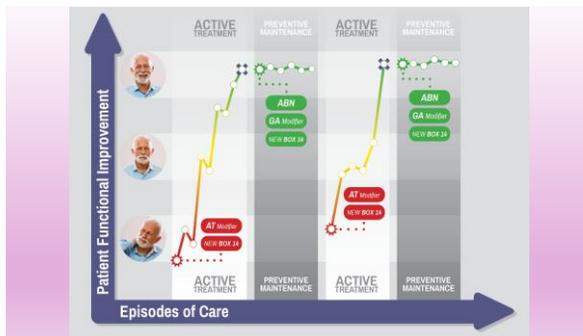
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The Opposite of Active Treatment

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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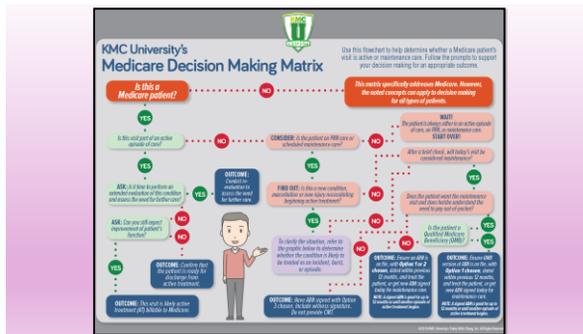
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The KMC University's Guide to MEDICARE MODIFIERS		
Modifiers Used Only With 90940, 90941, 90942		
Code	Description/Restriction	Effect on Medicare Payment
AT	Indicates a procedure or treatment indicates service rendered not medically necessary on Medicare secondary payer.	Medicare will consider for payment.
GA	Waiver of Liability (WOL) on file for secondary payer. Indicates insurance claim or other covered carrier review.	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.	Claims will be denied. Patient will not be deemed responsible for payment.
Modifiers Used with All Statutorily Excluded Services		Effect on Medicare Payment
GY	Indicates statutorily excluded services are not required unless the patient requests. Patient is financially liable.	Billing of these services is not required unless the patient requests. Patient is financially liable.
GX	WOL on file for voluntary use.	Claims will be considered financially liable; we don't recommend Medicare's official ABN form for voluntary use.
GP	Used for certain therapy services as part of occupational treatment plan.	Claims will be considered financially liable. Use with GY modifier on certain therapy services to receive proper denial.

MANDATORY SUBMISSION

VOLUNTARY SUBMISSION

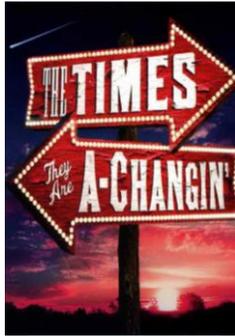
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Let's be clear:

- 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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Your Passion is Also a Regulated Business

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Parts of an Effective Office Compliance Program

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

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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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### 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.

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

(p. 7651) We believe that undertaking off-site or national 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 a larger setting, such as a multi-specialty group.

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### 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.”**

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Department of Health and Human Services  
OFFICE OF INSPECTOR GENERAL

A MICHIGAN CHIROPRACTOR RECEIVED CHALLENGABLE MEDICAL PAYMENTS FOR CHIROPRACTIC SERVICES

<http://www.hhs.gov/osp/inspect/whistleblower/>

## AUGUST 2016

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

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**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



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**OIG Recommends Policies and Procedures to Address THESE Risks**

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**Elements of an OIG Compliance Program**



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March 2015

**OHCA and HHS: Save over \$2.8 Billion in Returns from Joint Efforts to Combat Health Care Fraud**  
*Administrative recovery of \$2.8 billion from joint effort to fight health care fraud and abuse. About \$1 billion in savings.*

More than \$2.8 billion has been returned to the Medicare Trust Fund over the fall of the Health Care Fraud and Abuse Control (HCAC) 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 \$3.1 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 long-term care. For every dollar spent on health care-related fraud and abuse investigations in the last three years, the administration recovered \$7.76. This is about 82 percent higher than the average return on investment in the HCAC program since it was created in 1997. It is also the third-highest return on investment in the life of the program.

The successes reflect a two-pronged strategy to combat fraud and abuse. Under new authority granted by the Affordable Care Act, the administration continues to reform programs that were once "low-fee, low-risk" and other efforts regarding limitations to governing health care fraud and abuse in the real world. In addition, the Health Care Fraud Prevention and Enforcement Action Team (HEAT), now 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 in lieu of a traditional subpoena and lawsuit process, 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 in the program to bill 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 revulidation of all existing 1 million Medicare suppliers and providers under new screening requirements. CMS will have completed all revulidations by March 2015. As a result of this and other preventive measures, CMS has deactivated 470,000 overpayments and recouped nearly 28,000 overpayments to prevent current providers from re-billing and billing the Medicare program.

CMS also continued the fiscal 2014 temporary moratorium on the enrollment of new home health or ambulatory service providers in six fraud hot spots. This extension will allow CMS to continue its actions to suspend payments to remote providers from the program before allowing new providers into generally 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, real-time basis. The Fraud Prevention System identifies abnormal and suspicious billing patterns, which in turn trigger actions that can be implemented quickly to prevent or curtail fraudulent claims. In the second year, the system saved \$21.57 million, almost double the amount identified during the first year of the program.

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Can We Say Mitigating Factor Boys and Girls?

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What An OIG Compliance Program Isn't

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A "Program" is Not a "Manual"

ELEMENTS OF AN EFFECTIVE COMPLIANCE PROGRAM

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The Gospel According to KMC...

"It's ridiculous to think that in today's climate 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."

UTTERLY RIDICULOUS

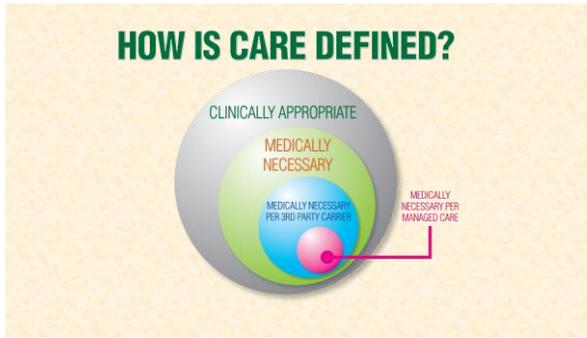
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KMC's "Either/Or" Principle  
 Traditional Part B Medicare

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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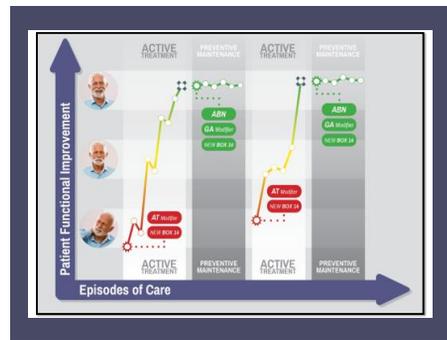
### Is All Care Medically Necessary?

<b>Clinically Appropriate Care</b> <ul style="list-style-type: none"> <li>• Maintenance care</li> <li>• Supportive care</li> <li>• Palliative care</li> <li>• Life enhancing and wellness care</li> <li>• Symptom relieving only</li> <li>• Care that doesn't have as its goal improved function and correction</li> <li>• All care within your scope of practice, because Doctor is your first name</li> </ul>	<b>Medically Necessary Care</b> <ul style="list-style-type: none"> <li>• Acute problems</li> <li>• Care that can provide measurable functional improvement</li> <li>• Chronic care with expected functional improvement</li> <li>• Often defined by the carrier's medical policy</li> </ul>
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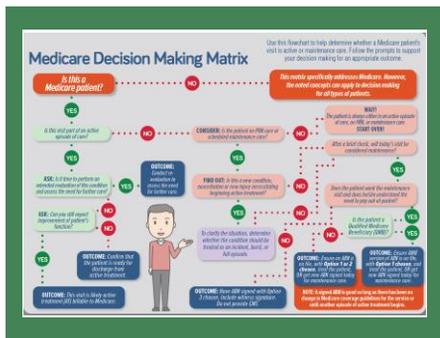
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Medical Necessity = Coverage parameters set and defined by third-party payers

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### Not Medicare Only...

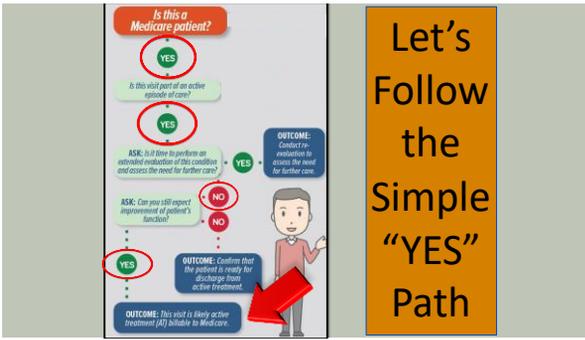
Use this flowchart to help determine whether a Medicare patient's visit may be active or maintenance care. Follow the prompts to support your decision making for an appropriate outcome.

Is this a Medicare patient? **NO**

This Matrix addresses Medicare specifically. However, the concepts and flow can apply to private payers for all types of patients.

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

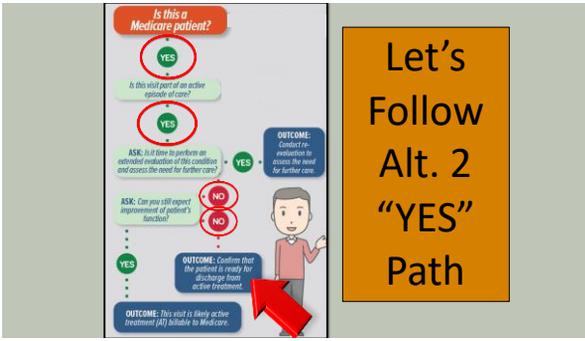
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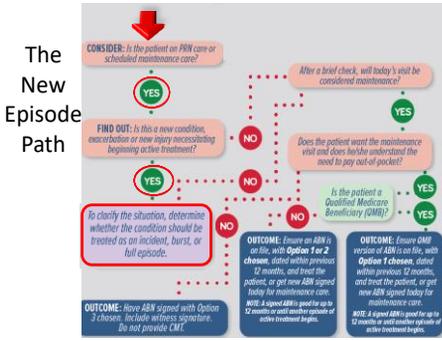
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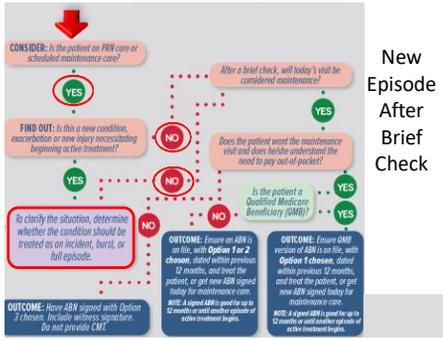
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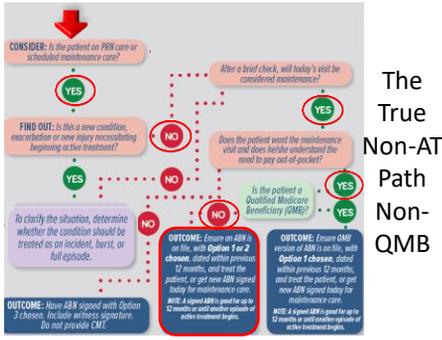
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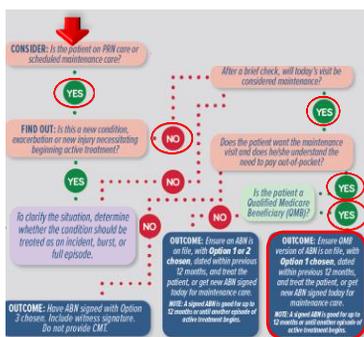
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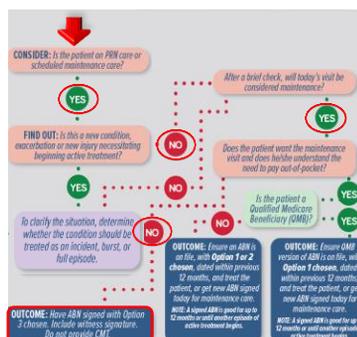


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The True Non-AT Path For a QMB

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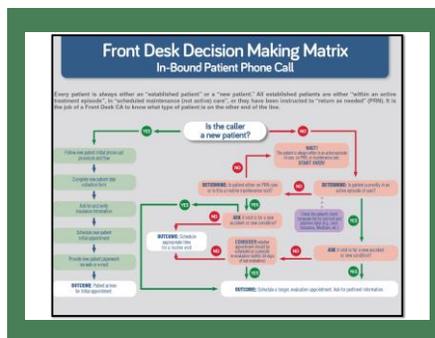
The Non-AT Path "No Thank You"

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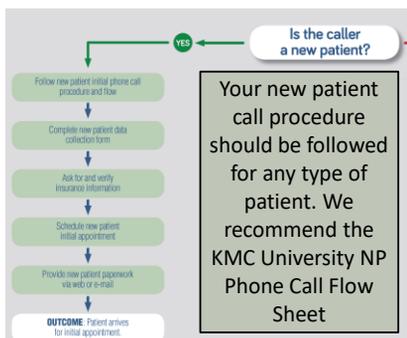
How CAs Can Be Of Assistance

1. Screen
2. Schedule
3. Support

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**New Patient Data Collection Form**

(This portion of the call screens the patients that they have called the right place.)

Name: Mary Jones

Who may we thank for referring you? Husband Mark Jones

What type of problem are you having? Severe neck pain after sleeping awkwardly

How long has this been going on? About a week

Result of accident? No

What have you done for this?
 

- OTC Meds
- Tylenol
- Massage
- Saw DC
- Saw MD
- Other

(Tell your doctor you saw this problem before and has had great results. Express compassion and concern when speaking to new patients.)

Appointment Date/Time: Wednesday October 27 9am

Now I'm going to ask you some questions that will save you time when you are in the office...
 

- Address: 124 Main Street
- City: Orange State: CA ZIP: 92669 Phone: 914-236-5697
- DOB: 12/23/41
- Email Address: MaryS@yahoo.com
- Call Home

Do you have some kind of insurance that you'd like us to assist in filling for you? Yes No

Would you please get your insurance/Medicare Card/accident information so we can review it? Yes No

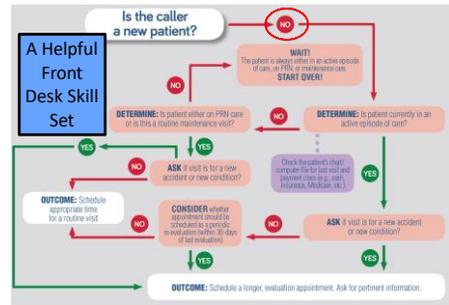
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Do you have some kind of insurance that you'd like us to assist in filling for you?  Yes  No  
 Would you please get your insurance benefits card/accident information so we can review it?

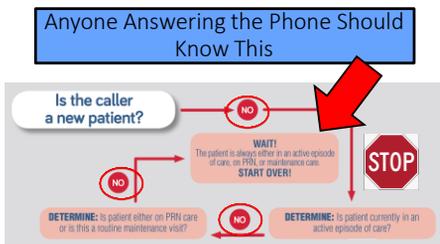
MAJOR MEDICAL INSURANCE	MEDICARE	ACCIDENT / INJURY	WORKERS COMPENSATION
United Health Care Insurance Company 800-965-4587 Phone: Self Insured 12/23/41 Insured DOB: AP5864KL ID#: 159753 Policy#: Group#: Employer:	Traditional Medicare MBI: K978G42FM01 Patient's Primary or Self Insurer <input type="checkbox"/> True Secondary or Supplemental (Medigap) <input checked="" type="checkbox"/> All other coverage is retained, patient retains or adds to all other insurance coverage (see call log)	Reported? <input type="radio"/> YES <input type="radio"/> NO Insurance Company: Claim#: Adjuster: Phone#: DOI: Date:	Reported? <input type="radio"/> YES <input type="radio"/> NO Supervisor: Phone#: Supervisor or HR: DOI: Claim#: Staff Member: Time:

Nonfirm Office Location   
  NP Paperwork   
  Website   
  Email   
 Discussed Fees/CHUs:  YES  NO

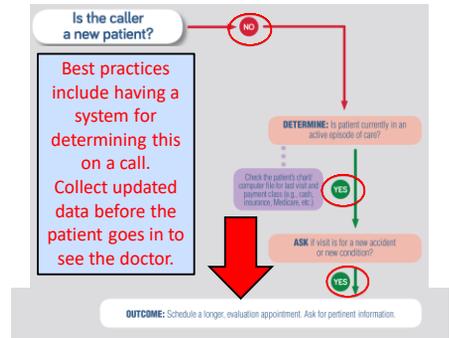
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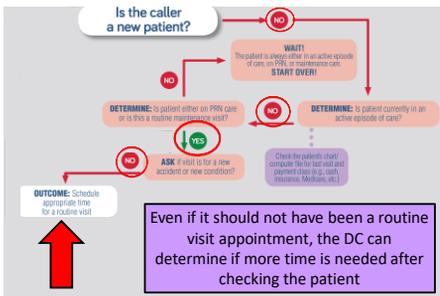
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Open Forum for Questions and Issues

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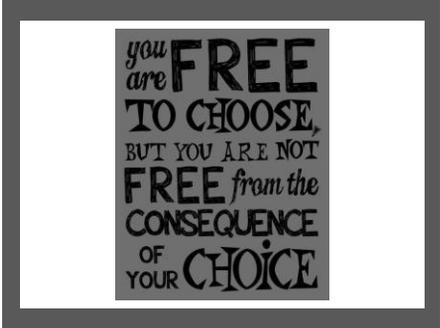
© 2012, Open Forum for Questions and Issues

You Don't Have to KNOW All the Answers...

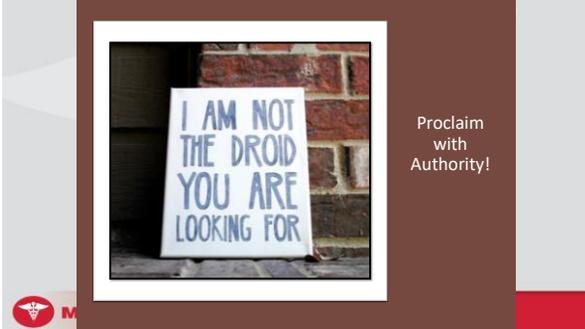
- Follow Official Coding Rules and Guidelines
- Have *current* coding resources available
- Rely on a certified coding specialist when you have questions, not your buddy!
- Ongoing training is essential and your obligation!



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