

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



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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?



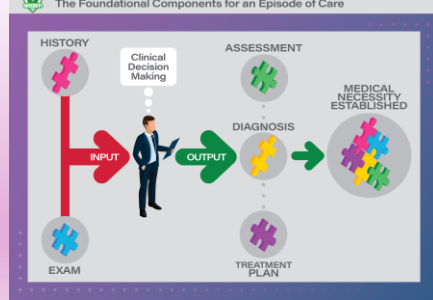
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Your Patient's Flow Under Care



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The Foundational Components for an Episode of Care



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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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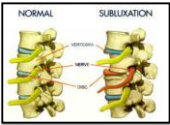
AT = Active Treatment

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

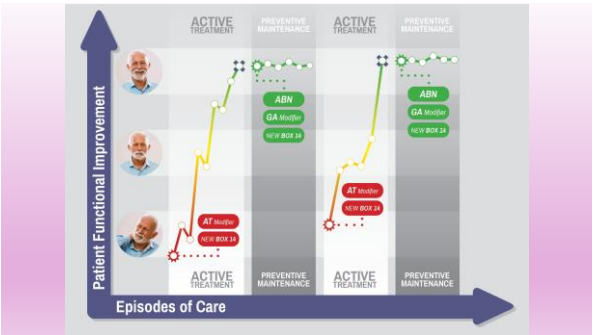
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The Opposite of Active Treatment

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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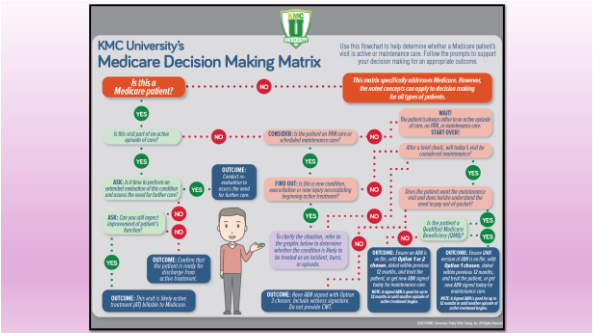
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The KMC University's Guide to MEDICARE MODIFIERS		
Modifiers Used Only With 90940, 90941, 90942		
Code	Description/Restriction	Effect on Medicare Payment
AT	Neurophysiotherapy treatment (includes service rendered and medically necessary per Medicare guidelines)	Medicare will consider for payment.
GA	Waiver of Liability (WOL) on file for mandatory use (includes maintenance care or any covered center services)	If patient selects ADR Option 1, you must bill Medicare. Medicare will deny as not medically necessary. Patient will be financially responsible.
GZ	Indicates you failed to collect ADR for maintenance care as required	Claims will be denied. Patient will not be deemed responsible for payment.
Modifiers Used with All Statutorily Excluded Services		
Code	Description/Restriction	Effect on Medicare Payment
GY	Indicates statutory non-coverage (maintenance is covered by a D.C.)	Billing of these services is not required unless the patient requests. Patient is financially liable.
GX	ADR on file for voluntary use	Claims will be denied/patient financially liable; we don't recommend Medicare's official ADR form for voluntary use.
GP	Used for certain therapy services as part of outpatient treatment plan	Claims will be denied/patient financially liable. Use with GY modifier on certain therapy services to receive proper denial.

MANDATORY SUBMISSION

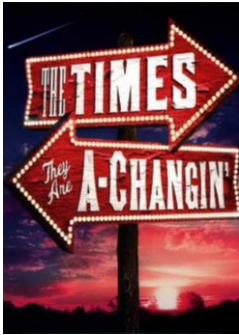
VOLUNTARY SUBMISSION

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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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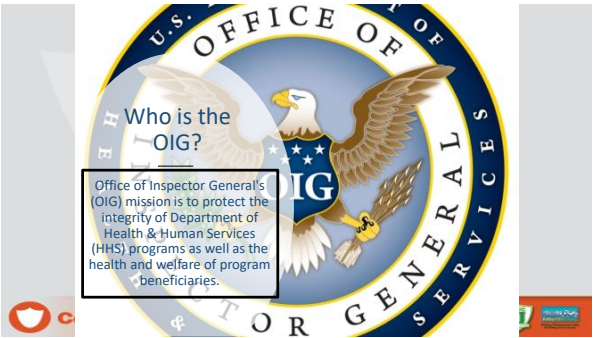


Your Passion is Also a Regulated Business

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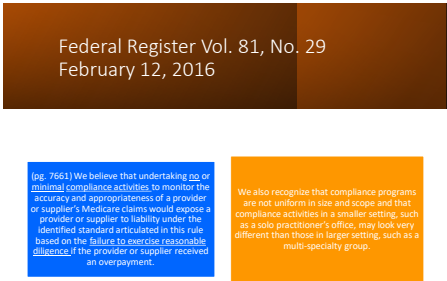
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Outliers Audited & Made Example

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 UNALLOWABLE MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES

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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What An OIG Compliance Program IS

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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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FINANCIAL INCORRECTNESS

MEDICAL NECESSITY

REVENUE AND CODING ERRORS

NON-RECORDED/INDEXED

OIG Recommends Policies and Procedures to Address THESE Risks

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Elements of an OIG Compliance Program

ESTABLISH AND IMPLEMENT POLICIES AND PROCEDURES

ASSIGN A COMPLIANCE OFFICIAL OR CONTACT

EMPLOY COMPREHENSIVE EDUCATION AND TRAINING

ENFORCE DISCIPLINARY STANDARDS

RESPOND SWIFTLY TO DETECTED OFFENSES

PERFORM INTERNAL AUDITING AND MONITORING

MAINTAIN OPEN LINES OF COMMUNICATION

RESEARCH AND DOCUMENT ALL STAFF AND PROVIDER

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March 2015

IRS and HHS Announce over \$2.8 Billion in Refunds from Joint Efforts to Combat Health Care Fraud
Administration received \$7.5 billion more dollar spent on fight health care-related fraud and abuse. Also highest on record.

More than \$2.8 billion has been returned to the Medicare Trust Fund over the life of the Health Care Fraud and Abuse Control (HC FAC) 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 \$7.75. This is about 12 times higher than the average return on investment in the HC FAC 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 authorities granted by the Affordable Care Act, the administration continues to implement programs that were once known as "tip and share" efforts regarding insurance to governing 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 IRS Office of the Inspector General and Department of Justice (OIG) 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 prolonged subpoena and account analysis, 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 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 revocation of all existing 1.5 million Medicare suppliers and providers under new screening requirements. CMS will have completed all revocations by March 2015. As a result of this and other preventive measures, CMS has deactivated 470,000 overpayments and avoided nearly 28,000 overpayments to prevent future providers from re-enrolling 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 its fraud hot spot. 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 responsive 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 \$21.7 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"



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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."



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

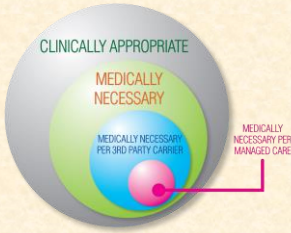
Either enrolled with Medicare or don't see Medicare Patients
Either covered service or statutorily excluded service
Either Medicare responsible or patient responsible
Either active treatment or maintenance care
Either mandatory ABN or voluntary ABN
CMT is either AT or GA



Never S8990 with Traditional Part B Medicare

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HOW IS CARE DEFINED?



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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**

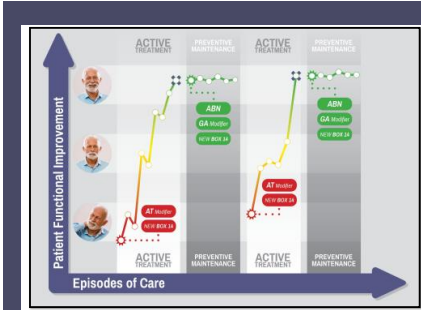
 - Acute problems
 - Care that can provide measurable functional improvement
 - Chronic care with expected functional improvement
 - Often defined by the carrier's medical policy

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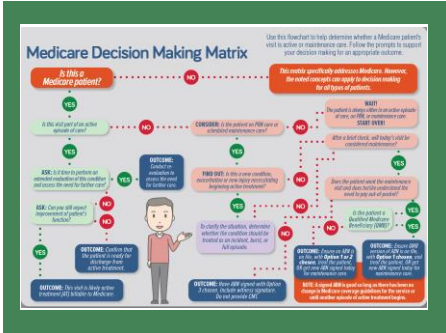


Medical Necessity = Coverage parameters set and defined by third-party payers

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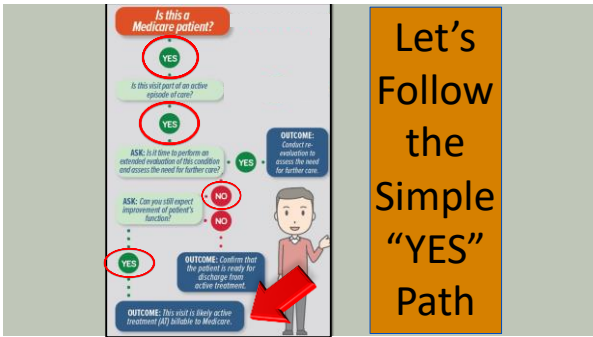
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Not Medicare Only...

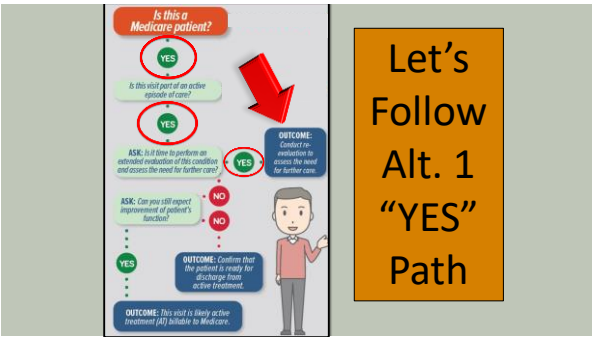


The concept of medical necessity, active episodes of care, and maintenance care are the same for any type of third-party pay situation

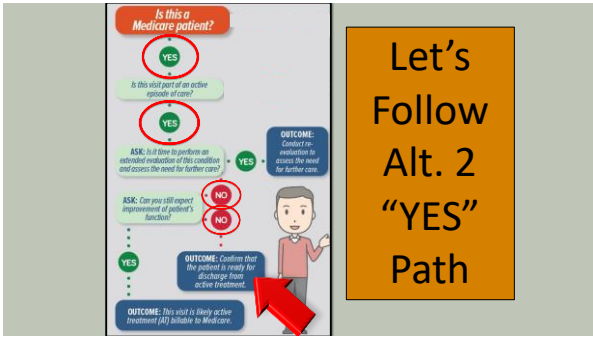
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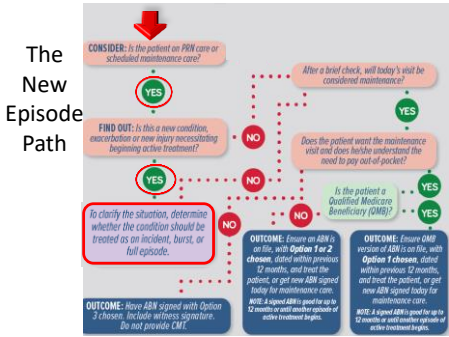
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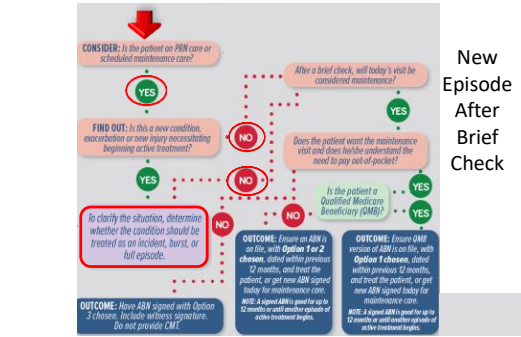
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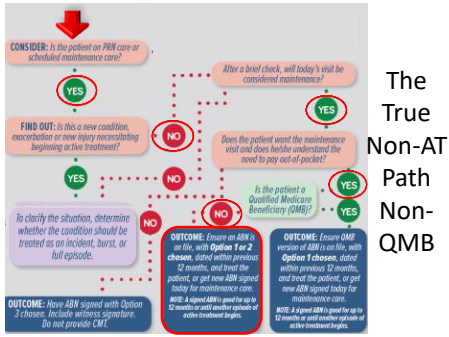
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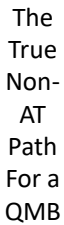
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graph TD
    A[CONSIDER: Is the patient on PMN care or scheduled maintenance?] -- YES --> B[FIND OUT: Is this a new condition, exacerbation or new injury necessitating beginning or acute treatment?]
    A -- NO --> C[Does the patient want the maintenance visit and does he/she understand the need to stay up-to-date?]
    B -- YES --> D[OUTCOME: Ensure ART signed with Option 3 chosen. Include written signature, and red stamped CMT.]
    B -- NO --> C
    C -- YES --> E[Is the patient a Qualified Medicare Beneficiary QMB?]
    C -- NO --> F[OUTCOME: Ensure on ART on file with Option 1 or 2 chosen. Signed within previous 12 months, and treat the patient or caregiver ART signed into the maintenance care.]
    E -- YES --> G[OUTCOME: Ensure QMB version of ART on file with Option 3 chosen. Signed within previous 12 months and the patient or caregiver ART signed into the maintenance care.]
    E -- NO --> F
    F --> H[To clarify the situation, determine whether the condition should be treated as an incident, burst, or full episode.]
    H -- YES --> D
    H -- NO --> G
  
```

CONSIDER: Is the patient on PMN care or scheduled maintenance?

YES

FIND OUT: Is this a new condition, exacerbation or new injury necessitating beginning or acute treatment?

YES

OUTCOME: Ensure ART signed with Option 3 chosen. Include written signature, and red stamped CMT.

NO

Does the patient want the maintenance visit and does he/she understand the need to stay up-to-date?

YES

Is the patient a Qualified Medicare Beneficiary (QMB)?

YES

OUTCOME: Ensure QMB version of ART on file with Option 3 chosen. Signed within previous 12 months and the patient or caregiver ART signed into the maintenance care.

NO

OUTCOME: Ensure on ART on file with Option 1 or 2 chosen. Signed within previous 12 months, and treat the patient or caregiver ART signed into the maintenance care.

To clarify the situation, determine whether the condition should be treated as an incident, burst, or full episode.


YES

OUTCOME: Ensure ART signed with Option 3 chosen. Include written signature, and red stamped CMT.

NO

OUTCOME: Ensure QMB version of ART on file with Option 3 chosen. Signed within previous 12 months and the patient or caregiver ART signed into the maintenance care.

The
Non-AT
Path
“No
Thank
You”



How CAs
Can Be Of
Assistance

1. Screen
2. Schedule
3. Support

How CAs Can Be Of Assistance

1. Screen
2. Schedule
3. Support

Front Desk Decision Making Matrix
Inbound Patient Phone Call

Every patient is always either an "established patient" or a "new patient." All established patients are either "return on schedule" or "return on expedite." All "return on expedite" patients are either "return on expedite" or "return on schedule" (PPO). It is the job of a front desk CNA to know what type of patient is on the other side of the line.

```

graph TD
    Start([Start]) --> Q1{Is the caller a new patient?}
    Q1 -- NO --> S1[Have the patient's personal information entered into the system?]
    S1 --> S2[Complete the patient's chart.]
    S2 --> S3[Add the patient's insurance information.]
    S3 --> S4[Print out the patient's appointment card.]
    S4 --> S5[Direct the new patient to the appointment.]
    S5 --> End([End])

    Q1 -- YES --> Q2{RETURNING: Returning to the office in 30-60 minutes expedite call?}
    Q2 -- YES --> S6[Check the patient's appointment card.]
    S6 --> S7[Check the patient's insurance information.]
    S7 --> S8[Print out the patient's appointment card.]
    S8 --> S9[Direct the returning patient to the appointment.]
    S9 --> End

    Q2 -- NO --> Q3{RETURNING: Returning to the office in 30-60 minutes schedule call?}
    Q3 -- YES --> S10[Check the patient's appointment card.]
    S10 --> S11[Check the patient's insurance information.]
    S11 --> S12[Print out the patient's appointment card.]
    S12 --> S13[Direct the returning patient to the appointment.]
    S13 --> End

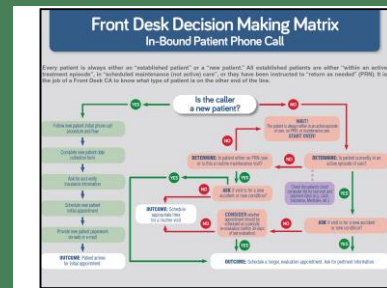
    Q3 -- NO --> Q4{NEW: New patient to the office in 30-60 minutes expedite call?}
    Q4 -- YES --> S14[Check the patient's appointment card.]
    S14 --> S15[Check the patient's insurance information.]
    S15 --> S16[Print out the patient's appointment card.]
    S16 --> S17[Direct the new patient to the appointment.]
    S17 --> End

    Q4 -- NO --> Q5{NEW: New patient to the office in 30-60 minutes schedule call?}
    Q5 -- YES --> S18[Check the patient's appointment card.]
    S18 --> S19[Check the patient's insurance information.]
    S19 --> S20[Print out the patient's appointment card.]
    S20 --> S21[Direct the new patient to the appointment.]
    S21 --> End

    Q5 -- NO --> End
  
```

DETERMINE: What type of patient is on the phone?

RECORD: Schedule a date, time, and appointment. Add the patient's information.



```

graph TD
    Q[Is the caller a new patient?] -- YES --> S1[Follow new patient initial phone call procedure and flow]
    S1 --> S2[Complete new patient data collection form]
    S2 --> S3[Ask for and verify insurance information]
    S3 --> S4[Schedule new patient initial appointment]
    S4 --> S5[Provide new patient paperwork via web or e-mail]
    S5 --> S6[Patient arrives for initial appointment]
    S6 --> O[OUTCOME]
  
```

Is the caller a new patient?

YES

Follow new patient initial phone call procedure and flow

Complete new patient data collection form

Ask for and verify insurance information

Schedule new patient initial appointment

Provide new patient paperwork via web or e-mail

OUTCOME Patient arrives for initial appointment

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

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

New Patient Data Collection Form

(Duplicate if the client measures the patients that have called the right place.)

Name: Mary Jones Husband Mark Jones


*Who may we thank for referring you? _____

*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? *Yes ____ No ____

*What have you done for this? _____
☒ IFC Meds Tylenol ☐ Massage ☐ Saw DC
 ☐ Other

(Fill in your doctor he seen this problem before and has had great results. Explain symptoms and concerns when speaking to our 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: MaryJ@yaho.com ☐ Male ☒ Female

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

*Would you please get your Insurance/Medicare Card/member Information so we can review it?

New Patient Data Collection Form

(Is the new doctor the same this problem before and has had great results. Explain experience and concern after speaking to the patient.)

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? **Yes** No

What have you done for this? **ATC/DC: Tylenol** Message Save DC

(Is the new doctor the same this problem before and has had great results. Explain experience and concern after speaking to the patient.)

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** DOB: **12/23/41**

City: **Orange** State: **CA** Zip: **92669** Phone: **014-236-5897** Cell Home

Email Address: **MaryS@yaho.com**

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

Do you please get your insurance/Medicare/Medicaid/Indemnification information so we can review R?

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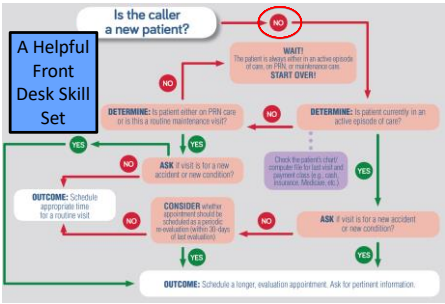
Do you have some kind of insurance that you'd like us to assist in filing for you? ☐ Yes ☒ No

Would you please get your insurance/medical/accident information so we can review it?

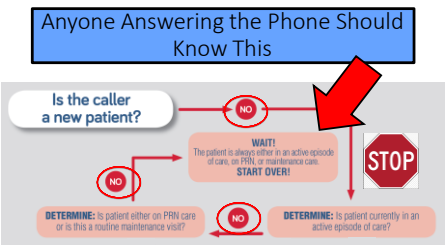
MAJOR MEDICAL INSURANCE	MEDICARE	ACCIDENT / INJURY	WORKERS COMPENSATION
United Health Care Insurance Company 800-965-4587 Phone: Self Insured 12/23/41 Insured DOB: AP5864KL ID#: 159753 Policy#: Group#: Employer:	Traditional Medicare MBL: K978G42FM01 Active Phase of Last Insurance: <input type="radio"/> True Secondary or Supplemental/ Medigap If both coverage is selected, please indicate as such. If either coverage, please enter date of loss. OR Medicare Replacement Plan Name of plan: Office participates: <input type="radio"/> YES <input type="radio"/> NO	Reported? <input type="radio"/> YES <input type="radio"/> NO Insurance Company: Claim#: Adjuster: Phone#: DOI: Claim#: Date: Time: Staff Member:	Reported? <input type="radio"/> YES <input type="radio"/> NO Supervisor: Phone#: Supervisor or HR: DOI: Claim#:

Confirm Office Location: ☐ NP Paperwork: ☐ Website: ☐ Email: ☐ Discussed Fees/CHARGE: ☐ YES ☐ NO

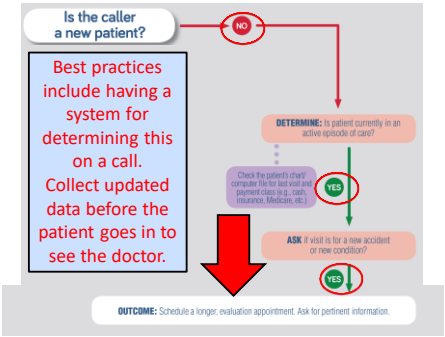
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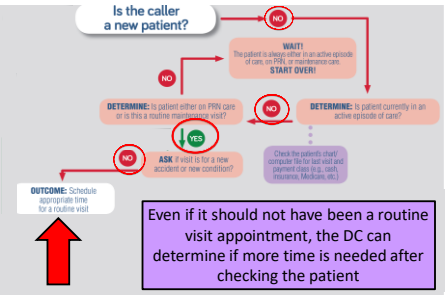
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Open Forum for Questions and Issues

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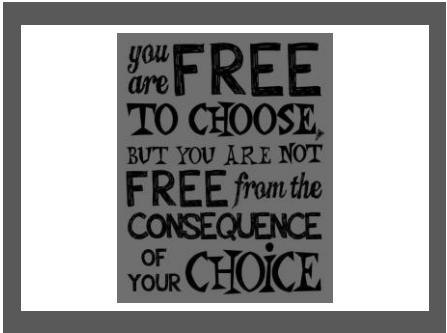


You Don't Have to KNOW All the Answers...

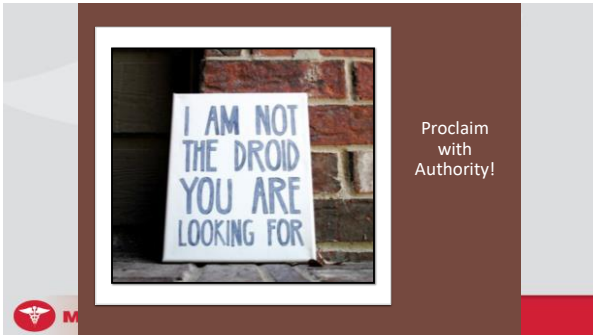
- Follow Official Coding Rules and Guidelines
- Have *current* coding resources available
- Rely on a certified coding specialist when you have questions, not your buddy!
- Ongoing training is essential and your obligation!



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