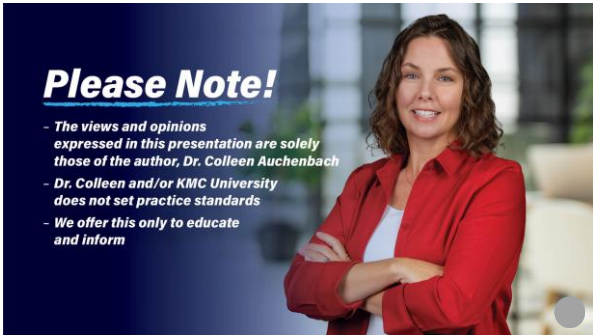




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## Government's Healthcare Oversight

- 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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## Office of Inspector General

<http://oig.hhs.gov/>

- The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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## Operating Components



Office of Audit Services



Office of Evaluation and Inspections



Office of Investigations



Office of Counsel to the Inspector General

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## Office of Audit Services

- The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

16

## OIG Findings

The practice did not comply with Medicare billing requirements for the chiropractic service line items that we sampled.

Specifically, the medical records did not support the medical necessity for any of the sampled chiropractic service line items.

Based on the sample results, an estimated amount was determined as unallowable for Medicare reimbursement.

This amount included claims outside of the 3-year claims recovery period.

These overpayments occurred because of lack of adequate policies and procedures to ensure that the medical necessity of chiropractic services billed to Medicare was adequately documented in the medical records.

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## OIG Findings

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18



### OIG Recommendations

1

Refund to the estimated overpayments for claims incorrectly billed that were within the 3-year claims recovery period

2

Work with the Medicare administrative contractor that processed and paid the Medicare claims to return overpayments outside of the 3-year claims recovery period in accordance with the 60-day repayment rule

3

Establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are adequately documented in the medical records

19

### OIG Recommendations

1

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2

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3

Establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are adequately documented in the medical records

20

### What Does Medicare Cover?

"Medicare covers chiropractic services provided by a qualified chiropractor. Medicare requires that these services be reasonable and necessary for the treatment of a beneficiary's illness or injury. Medicare limits coverage of chiropractic services to manual manipulation of the spine to correct a subluxation (when spinal bones lose their normal position). To receive payment from Medicare, a chiropractor must document the services as required by the Centers for Medicare & Medicaid Services' Medicare Benefit Policy Manual and the applicable Local Coverage Determination for chiropractic services. In addition, depending on the number of spinal regions treated, chiropractors may bill Medicare for chiropractic manipulative treatment using one of three procedure codes."

21

### Medicare Coverage of Chiropractic Services

Medicare Part B covers chiropractic services provided by a qualified chiropractor. To provide such services, a chiropractor must be licensed or legally authorized by the State or jurisdiction in which the services are provided.

Medicare requires that chiropractic services be reasonable and necessary for the treatment of a beneficiary's illness or injury, and Medicare limits coverage of chiropractic services to manual manipulation (i.e., by using the hands) of the spine to correct a subluxation. Chiropractors may also use manual devices to manipulate the spine.

To substantiate a claim for manipulation of the spine, the chiropractor must specify the precise level of subluxation, depending on the number of spinal regions treated. Chiropractors may bill Medicare for chiropractic manipulative treatment using one of three Current Procedural Terminology (CPT) codes: 98940 (for treatment of one to two regions), 98941 (for treatment of three to four regions), and 98942 (for treatment of five regions).

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### Medicare Coverage of Chiropractic Services

Medicare requires chiropractors to place the AT (Acute Treatment) modifier on a claim when providing active/corrective treatment for subluxation. Because Medicare considers claims without the AT modifier to be claims for services that are maintenance therapy, it will deny these claims. However, inclusion of the AT modifier does not always indicate that the service provided was reasonable and necessary.

To receive payment from Medicare, a chiropractor must document the services provided during the initial and subsequent visits as required by the Manual and the applicable MAC's LCD for chiropractic services. Medicare pays the beneficiary or the chiropractor the amount allowed for payment according to the physician fee schedule, less the beneficiary share (i.e., deductibles and coinsurance).

23

### Medicare Appeals Process

There are five levels in the Medicare Part A and Part B appeals process. The levels are:

First Level of Appeal: Redetermination by a Medicare Administrative Contractor (MAC)

Second Level of Appeal: Reconsideration by a Qualified Independent Contractor (QIC)

Third Level of Appeal: Decision by the Office of Medicare Hearings and Appeals (OMHA)

Fourth Level of Appeal: Review by the Medicare Appeals Council

Fifth Level of Appeal: Judicial Review in Federal District Court

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### What Next?

- Training
- Compliance Certifications
- Implementation
- Patient Education
- Written Policies and Procedures

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### Checks and Balances



**REACTIVE**  
Reacting to a problem after it arises.

### MANAGEMENT STYLES



**PROACTIVE**  
Preventing problems before they arise.

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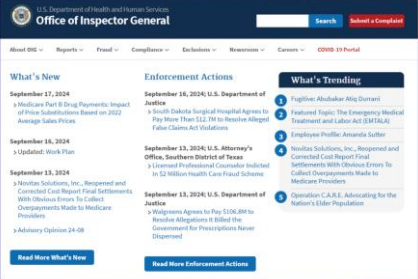
### Federal Register Vol. 81, No. 29 February 12, 2016

(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.**

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### OIG Website



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### HHS OIG Portfolio February 2018



U.S. Department of Health and Human Services  
Office of Inspector General

MEDICARE NEEDS BETTER CONTROLS TO PREVENT FRAUD, WASTE, AND ABUSE RELATED TO CHIROPRACTIC SERVICES

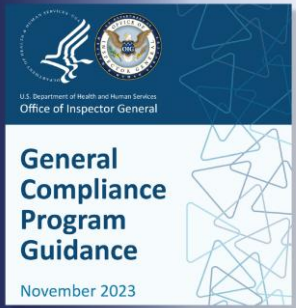
February 2018

An OIG Portfolio

A-09-16-02042

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### General Guidance



U.S. Department of Health and Human Services  
Office of Inspector General

**General Compliance Program Guidance**

November 2023

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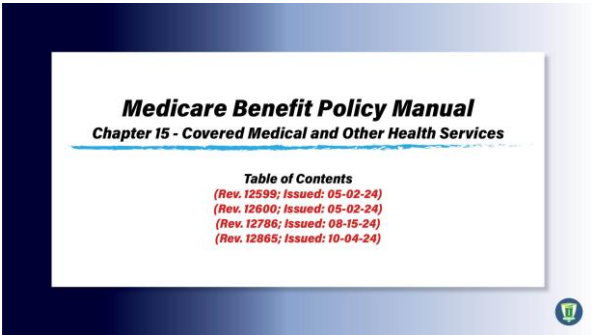
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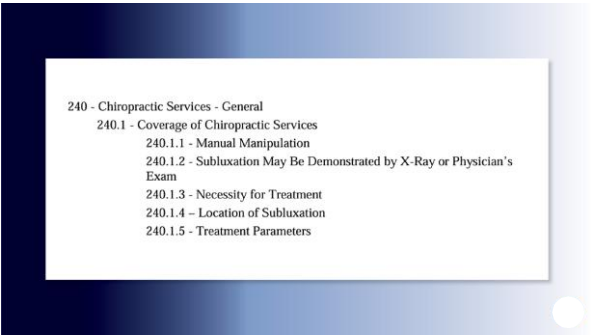
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**240 - Chiropractic Services - General**  
(Rev. 1, 10-01-03)  
B3-2250, B3-4118

The term "physician" under Part B includes a chiropractor who meets the specified qualifying requirements set forth in §30.1 but only for treatment by means of manual manipulation of the spine to correct a subluxation.

Effective for claims with dates of services on or after January 1, 2000, an x-ray is not required to demonstrate the subluxation.

Implementation of the chiropractic benefit requires an appreciation of the differences between chiropractic theory and experience and traditional medicine due to fundamental differences regarding etiology and theories of the pathogenesis of disease. Judgments about the reasonableness of chiropractic treatment must be based on the application of chiropractic principles. So that Medicare beneficiaries receive equitable adjudication of claims based on such principles and are not deprived of the benefits intended by the law, carriers may use chiropractic consultation in carrier review of Medicare chiropractic claims.

Payment is based on the physician fee schedule and made to the beneficiary or, on assignment, to the chiropractor.

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**Billing and Coding: Chiropractic Services**

AS9432

Expand All | Collapse All

**NOT AN LCD REFERENCE ARTICLE**  
This article is not in direct support of an LCD. Last updated: 2020-09-09

**Contractor Information**

Contractor Name	Contract Type	Contract Number	Jurisdiction	States
First Coast Service Options, Inc.	A and B MAC	09030 - MAC A	J - TN	Florida
First Coast Service Options, Inc.	A and B MAC	09030 - MAC B	J - TN	Florida
First Coast Service Options, Inc.	A and B MAC	09030 - MAC A	J - TN	Puerto Rico Virgin Islands
First Coast Service Options, Inc.	A and B MAC	09030 - MAC B	J - TN	Puerto Rico
First Coast Service Options, Inc.	A and B MAC	09030 - MAC B	J - TN	Virgin Islands

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**Known Violations: Per OIG**

- Submitted claims for services that were never provided
- Submitted claims for medically unnecessary services
- Offered incentives to patients to receive unnecessary services
- Provided services without a valid chiropractic license
- Falsified patient records, and
- Billed for chiropractic services but provided services not covered by Medicare (e.g., massage and acupuncture)

47

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



48



**Risk #1**



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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


**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

50


**#1 Failure: Active vs. Maintenance**

**WHAT THE DC SAYS**



"All the care I deliver is 'active' so I bill with the AT modifier 100% of the time."

**WHAT THE OIG SAYS**



"I'll bet you really don't know the definition of medical necessity if that's the case."

51

**Both Doctor and Patient Must Know When It's Active and When It's Maintenance**

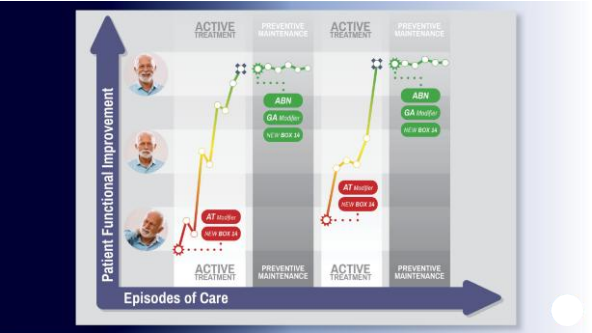


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**How is care defined?**



53



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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.**

55

**AT = Active Treatment**

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

56

The KMC University's Guide to MEDICARE MODIFIERS

Code	Description/Instructions	Effect on Medicare Payment
AT	Reporting Active Treatment. Medicare services rendered are medically necessary and Medicare payable.	Medicare will consider for payment.
GA	Non-Mandatory use. Medicare coverage is not required. Patient is financially responsible.	Cover will be denied. Patient will not be deemed responsible for payment.
GZ	Voluntary use. Medicare coverage is not required. Patient is financially responsible.	Cover will be denied. Patient will not be deemed responsible for payment.

MANDATORY SUBMISSION

VOLUNTARY SUBMISSION

57

**DCs Must Answer with Certainty!**

Is there a subluxation present, capable of causing a significant neuromusculoskeletal (NMS) condition, and does the patient have a documented loss of function that can be improved?

**If No...**

In this circumstance, per Medicare coverage requirements, medical necessity cannot be established and therefore the condition is likely maintenance care.

58

**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.

59

**Maintenance Expect Payment from Your Patient!**

- Wellness
- Preventive
- Promote health
- Prolong/enhance the quality of life
- Supportive
- Maintain or prevent deterioration of a chronic condition

60

**Use the AT Modifier Correctly!**

CMS' claim data analysis and audit results suggest that chiropractors submit claims with the AT modifier regardless of whether the services were for active/corrective treatment for subluxation.

The Active Treatment [AT] modifier was developed to clearly define the difference between active treatment and maintenance treatment. The AT modifier should not be used if maintenance therapy is being performed.

Your use of the AT modifier tells Medicare that all required documentation is being accurately maintained to support medical necessity.



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**WHAT THE DC SAYS**



"All the care we provide is active. Chiropractic care is always necessary, and Medicare should cover it."


**WHAT THE OIG HEARS**



"Hmmm... only active care? This doesn't sound like good case management. Initiate claim data analysis to compare service date to Box 14 date."

62


**Heightened Awareness of Hot Spots**



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

63

**Are You an Outlier?**



- Statistics tell us that the improper coding of full-spine treatment can cause you to appear to be an outlier
- You therefore can be subject to more scrutiny, red flags, and even an audit

STATISTICS

64

**Risk #2**



65

**Medical Necessity Care vs. Clinically Appropriate Care**




66



### What Not to Do!


- ❌ Documentation of an initial visit of an episode that looks like every other visit
- ❌ Initial visits of new episodes of care where the patient has no idea why they have pain... did you say "insidious onset"?
- ❌ Visits that are spaced at exactly a month apart, being billed as "AT" without proper justification-lack of case management
- ❌ Routine visit documentation that doesn't reflect the presence of a subluxation in each region treated



67


### The Life Cycle of the Patient's Record

- 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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### Good Documentation Tells a Story



69

### Why Do All Your Visits Look The Same, One After Another?



70

### EITHER

### E/M vs. SOAP

### OR

71

### What Medicare and Other 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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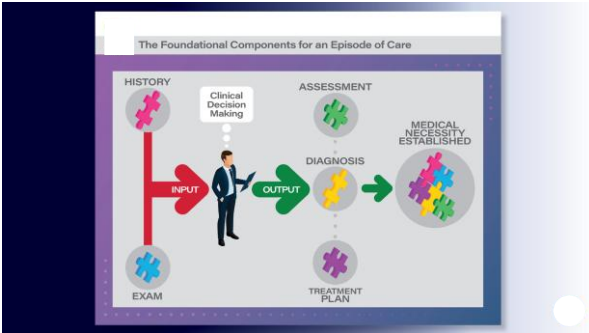
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### Medicare Documentation Guidelines in the Absence of Others

Initial Visit	Subsequent Visits
<ul style="list-style-type: none"><li>- History</li><li>- Description of Present Illness</li><li>- Physical Exam</li><li>- Diagnosis</li><li>- Treatment Plan</li><li>- Date of initial treatment</li></ul>	<ul style="list-style-type: none"><li>- History</li><li>- Review of chief complaint</li><li>- Physical Exam</li><li>- Document daily treatment</li><li>- Progress related to treatment goals/plan</li></ul>

80

### An Incident-Within SOAP Documentation

**Subjective:**  
Fred reported today complaining of increased lower back pain after falling over his dog two days ago. He fell onto his left side, striking his left lower back and hip area hard on the concrete. He had immediate pain in the left lumbar, pelvic and sacral area, and a "stiffness" in the mid-thoracic spine. The pain has remained the same since the incident. It is stiff and sore, but doesn't radiate. He's used ice in the area but done nothing else so far. Standing is easier than sitting. He rates the lower back, pelvic and sacral pain at 7/10, 10 being worst. Previous treatment in this office was rendered for a similar condition, but he's been released from active care for over 8 months. Fred was last seen two months ago for routine maintenance care. Current ability to sit for only 10 minutes without pain. Previous normal was up to 30 minutes.

**Objective:**  
- **Inspection/Perkussion** Positive upon palpation at L2-S, S1 and the left SI joint posterior cervical (neck)  
- **Postural Analysis:** short right leg (pelvic deficiency)  
- **Range of Motion:** Lumbar ROM reduced as follows: Flexion: 60/90 with pain; Left Lateral Flexion: 25/35 with pain; Left Rotation: 20/30 with pain  
- **Spinal Stability/Restriction(s)/Subluxation(s):** L2, L3, L4, L5, S1, Left SI  
- **Tissue Tone Changes:** Muscle spasms present throughout the lumbar paraspinal musculature, left hip and pelvic region

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### An Incident-Within SOAP Documentation

**Assessment:**  
Fred has suffered a recurrence of lower back pain after his hip and fall. He has been treated for these conditions previously in this office and based on my knowledge of this case, I see no reason that he won't progress well from this setback. The multiple examinations of his lower back condition may cause slower than normal recovery, but overall, I expect Fred to respond well. There are no contraindications to conservative chiropractic treatment at this time. I predict Fred will reach pre-injury norms within the next two weeks.

**Diagnosis:**  
Upon consideration of the information available the diagnosis is: (M59.03) Sag and somatic dysf. of lumbar reg. (M54.3) Lumbago, (M59.04) Sag and somatic dysf. of sacral reg. (S33.0XXA) Strain of SI joint, Initial Encounter. (M59.05) Sag and somatic dysf. of pelvic reg. (S39.013A) Pelvic strain, Initial Encounter

**Plan:**  
- **Primary Treatment:** Diversified and Drop Table- Chiropractic Manipulative Treatment (CMT) to the L2, L3, L4, L5, S1, Left SI spinal levels for 2-4 visits over the next two weeks.  
- **Goal:** Resume ability to sit up to 30 minutes without pain  
- **Treatment Effectiveness:** Treatment will be evaluated by monitoring pain scale and range of motion in the lumbar spine. Optimal pain goal <2/10 and lumbar ROM improved to pre-injury norms.  
**Home/Self-Care:** Patient advised to use ice once per hour for up to 10 minutes, PRN for pain

**Today's Treatment:** Chiropractic Manipulative Treatment (CMT) to the L2, L3, L4, L5, S1, Left SI spinal levels

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### Risk #3

**BILLING AND CODING ERRORS**

97530 98942 G0283 97012 97112

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### Billing

- Eligibility to see Medicare patients-Part B & Part C
- Billing/Charging Medicare
- Billing/Charging Patients

### Coding

- Representing services with codes (CPT/HCPCS)
- Diagnosis Coding
- Modifiers

ICD-10-CM The Complete Official Codebook

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### CMT Coding and Regions

**Spinal:**

**Cervical:** The atlanto-occipital joint (C0/C1), and C1 through C7  
**Thoracic:** T1 through T12, including the posterior ribs (costoanverse and costovertebral joints)  
**Lumbar:** L1 through L5  
**Sacral:** The sacrum, including the sacroccocygeal joint  
**Pelvic:** The sacralia joints and other pelvic articulations

**Extraspinal:**

**Head:** Includes the TMJ, but excludes the atlanto-occipital joint  
**Upper Extremities:** Shoulder, arm, elbow, wrist) and hand  
**Lower Extremities:** Hip, leg, knee, ankle and foot  
**Rib Cage:** Anterior rib cage, including the costosternal joints, but excluding the costovertebral joints  
**Abdomen:** Includes the soft tissue of the abdomen

**The Codes:** There are three spinal CMT codes and one extraspinal CMT code. They are:

98940: CMT, 1 or 2 spinal regions as noted above  
98941: CMT, 3 or 4 spinal regions as noted above  
98942: CMT, 5 spinal regions as noted above  
98943: CMT, Extraspinal, 1 or more extraspinal regions as noted above



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### Suggested CMT Code Setup

- **Non-Medicare**  
Active Treatment adjustments-98940-98942
- **Medicare**  
Active Treatment adjustments- 98940-AT to 98942-AT
- **Non-Medicare**  
Maintenance adjustments: S8990
- **Medicare**  
Maintenance adjustments: 98940-GA to 98942-GA




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### The KMC University's Guide to MEDICARE MODIFIERS

Code	Description/Instructions	Effect on Medicare Payment
AT	Readily achieved/Consider treatment location services necessary or medically necessary or Medicare payable	Medicare will consider for payment.
GA	Not medically necessary, but Medicare will consider for payment if you must bill Medicare. Medicare will deny as not medically necessary. Patient will be financially responsible.	
GZ	Indicates care is denied under Z99.99. No maintenance care as required	Care will be denied. Patient will not be deemed responsible for payment.

**Modifiers Used with All Statutorily Excluded Services**

Code	Description/Instructions	Effect on Medicare Payment
GY	Indicates Statutorily non-covered services are covered by a PC.	Billing of these services is not required unless the patient requests. Patient is financially liable.
GX	Used for certain therapy services on and off outpatient treatment plan	Care will be denied/financially liable; we don't recommend Medicare's official AHA form for voluntary use.
GP	Used for certain therapy services on and off outpatient treatment plan	Care will be denied/financially liable. Use with GT modifier on certain therapy services to ensure proper denial.



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### Coding Oddities

- **Unattended electrical muscle stim**
- **Do not use 97014**
- **Use G0283**



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### Never Charge 97010

**HOT PACKS**

- For chronic pain relating to muscle aches & joint stiffness
- Increases blood flow by dilating blood vessels
- Promotes muscle relaxation & tissue healing

**COLD PACKS**

- For injuries and acute pain relating to inflammations
- Reduces blood flow by constricting blood vessels
- Numbs pain & reduces the effects of inflammations (swelling & redness) & bruising



89

### Suggested CMT Code Setup

- **Non-Medicare**  
Active Treatment adjustments-98940-98942
- **Medicare**  
Active Treatment adjustments- 98940-AT to 98942-AT
- **Non-Medicare**  
Maintenance adjustments: S8990
- **Medicare**  
Maintenance adjustments: 98940-GA to 98942-GA



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**Group 1 Codes:**  
**ICD-10 Codes**

ICD-10 Codes	Description
M99.00	Segmental and somatic dysfunction of head region
M99.01	Segmental and somatic dysfunction of cervical region
M99.02	Segmental and somatic dysfunction of thoracic region
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.05	Segmental and somatic dysfunction of pelvic region

**Primary DX Must Be Subluxation/ Segmental Dysfunction**

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**Group 2 Paragraph:**  
**Secondary Inguinal Codes**

Covered for:

ICD-10 Codes	Description
S32.00	Spontaneous life-threatening
S32.01	Spontaneous, multiple fractures and region
S32.02	Spontaneous, multiple fractures and region
S32.03	Spontaneous, multiple fractures and region
S32.04	Spontaneous, multiple fractures and region
S32.05	Spontaneous, multiple fractures and region
S32.06	Spontaneous, multiple fractures and region
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S32.09	Spontaneous, multiple fractures and region
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S32.84	Spontaneous, multiple fractures and region
S32.85	Spontaneous, multiple fractures and region
S32.86	Spontaneous, multiple fractures and region
S32.87	Spontaneous, multiple fractures and region
S32.88	Spontaneous, multiple fractures and region
S32.89	Spontaneous, multiple fractures and region
S32.90	Spontaneous, multiple fractures and region
S32.91	Spontaneous, multiple fractures and region
S32.92	Spontaneous, multiple fractures and region
S32.93	Spontaneous, multiple fractures and region
S32.94	Spontaneous, multiple fractures and region
S32.95	Spontaneous, multiple fractures and region
S32.96	Spontaneous, multiple fractures and region
S32.97	Spontaneous, multiple fractures and region
S32.98	Spontaneous, multiple fractures and region
S32.99	Spontaneous, multiple fractures and region

**Group 3 Paragraph:**  
**Group 3 Codes**

Covered for:

ICD-10 Codes	Description
S32.00	Spontaneous life-threatening
S32.01	Spontaneous, multiple fractures and region
S32.02	Spontaneous, multiple fractures and region
S32.03	Spontaneous, multiple fractures and region
S32.04	Spontaneous, multiple fractures and region
S32.05	Spontaneous, multiple fractures and region
S32.06	Spontaneous, multiple fractures and region
S32.07	Spontaneous, multiple fractures and region
S32.08	Spontaneous, multiple fractures and region
S32.09	Spontaneous, multiple fractures and region
S32.10	Spontaneous, multiple fractures and region
S32.11	Spontaneous, multiple fractures and region
S32.12	Spontaneous, multiple fractures and region
S32.13	Spontaneous, multiple fractures and region
S32.14	Spontaneous, multiple fractures and region
S32.15	Spontaneous, multiple fractures and region
S32.16	Spontaneous, multiple fractures and region
S32.17	Spontaneous, multiple fractures and region
S32.18	Spontaneous, multiple fractures and region
S32.19	Spontaneous, multiple fractures and region
S32.20	Spontaneous, multiple fractures and region
S32.21	Spontaneous, multiple fractures and region
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S32.23	Spontaneous, multiple fractures and region
S32.24	Spontaneous, multiple fractures and region
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S32.26	Spontaneous, multiple fractures and region
S32.27	Spontaneous, multiple fractures and region
S32.28	Spontaneous, multiple fractures and region
S32.29	Spontaneous, multiple fractures and region
S32.30	Spontaneous, multiple fractures and region
S32.31	Spontaneous, multiple fractures and region
S32.32	Spontaneous, multiple fractures and region
S32.33	Spontaneous, multiple fractures and region
S32.34	Spontaneous, multiple fractures and region
S32.35	Spontaneous, multiple fractures and region
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S32.37	Spontaneous, multiple fractures and region
S32.38	Spontaneous, multiple fractures and region
S32.39	Spontaneous, multiple fractures and region
S32.40	Spontaneous, multiple fractures and region
S32.41	Spontaneous, multiple fractures and region
S32.42	Spontaneous, multiple fractures and region
S32.43	Spontaneous, multiple fractures and region
S32.44	Spontaneous, multiple fractures and region
S32.45	Spontaneous, multiple fractures and region
S32.46	Spontaneous, multiple fractures and region
S32.47	Spontaneous, multiple fractures and region
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S32.80	Spontaneous, multiple fractures and region
S32.81	Spontaneous, multiple fractures and region
S32.82	Spontaneous, multiple fractures and region
S32.83	Spontaneous, multiple fractures and region
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S32.95	Spontaneous, multiple fractures and region
S32.96	Spontaneous, multiple fractures and region
S32.97	Spontaneous, multiple fractures and region
S32.98	Spontaneous, multiple fractures and region
S32.99	Spontaneous, multiple fractures and region

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**Diagnosis Hierarchy**

**Position 1:**  
Neurological/Injury: Examples of neurological diagnoses include Radiculitis and Sciatic Neuritis.

**Position 2:**  
Structural/Subluxation: Examples of structural diagnoses for the spine include Degenerative Joint Disease, Spondylolisthesis, Scoliosis, etc.

**Position 3:**  
Functional: Examples include Restricted Range of Motion, Deconditioning Syndrome, and muscle wasting.

**Position 4:**  
Soft Tissue/Extraspinal/Other: Fibromyalgia, myofascitis, and myalgia are excellent diagnoses to support manual therapy. Examples of extraspinal diagnoses include Frozen Shoulder, Carpal Tunnel Syndrome, Headache or Pain Syndromes.

**Position 5:**  
Complicating Factors: Examples include obesity, high blood pressure, diabetes, cancer, and other forms of co-morbidities.

**Position 6:**  
External cause, Activity, and Location Codes: Examples are related to mechanisms of injury, like slips, trips, falls and accidents, and activity codes show what the patient was doing when injured. These are not required, but helpful, and if reported are only reported on the first claim.

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**Medicare DX Coding**

The preferred order is the same but use the **required coupling** of the **primary segmental dysfunction diagnosis first**, and the **secondary neuromusculoskeletal diagnosis listed second in the pair**. Then move on to the next condition and repeat that coupling for the next condition.

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**Risk #4**

**PATIENT FINANCIAL INCONSISTENCIES**

95

**The Regulations**

Revised Guidelines Released  
Companies must act  
How to comply  
New Compliance Rules  
Regulations take effect  
Law Changes  
How rules affect you  
Deadline Set for New Business Rules

96

### False Claims Act Violations

- Establishes liability when any person or entity improperly receives from or avoids payment to the Feds
- Prohibits "knowingly presenting or causing to be presented, a false claim for payment or approval"
- Charging more to insurance than cash-paying patients may fall under this act
- Upcoding CMT codes due to full spine adjusting
- Misconduct experimental services to gain coverage

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### Avoid 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.

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### No 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

99

### Avoid Dual Fee Schedules

Charging insurance companies more than cash patients

- False Claims Act and Inducement Violations
- May violate provider agreements

100

### Improper Time of Service Discounts

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

Payment And Co-Pays Are Due At Time Of Service

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### Know Your Discounts & Know What Is and Isn't Legal

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**Red Flags for Chiropractors**

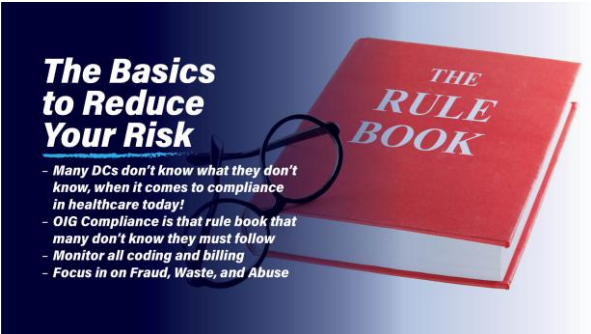
- Medicare claim data
- Spinal CMT Coding percentage
- Beneficiary Complaints



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**The Basics to Reduce Your Risk**

- Many DCs don't know what they don't know, when it comes to compliance in healthcare today!
- OIG Compliance is that rule book that many don't know they must follow
- Monitor all coding and billing
- Focus in on Fraud, Waste, and Abuse



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**Analyze Charges and Documentation Regularly**

- Stop the small leaks before there is a flood
- Focus on potential trouble spots
- Know the signs the watch for daily
- Self Auditing-Coding, EOB, Documentation



105

**You're Going to Find Some Things Wrong**



106

**Start an "Issues List"**

- Use to inform policy and procedure as you go
- Attack the hot spots first
- Use good planning logic and don't bite off more than you can chew
- Use a professional for compliance



107

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



108



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