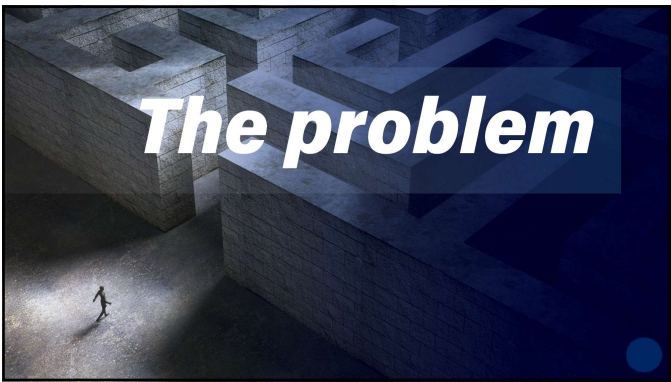




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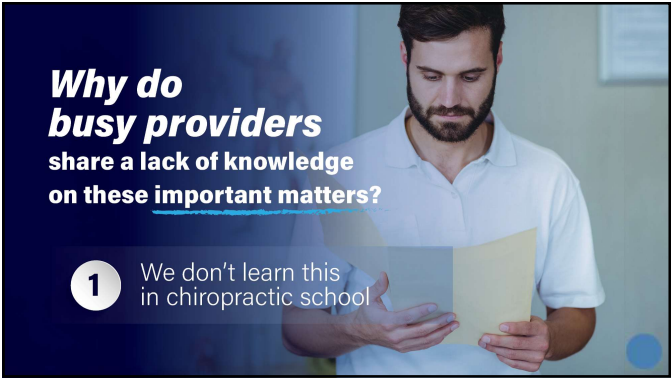
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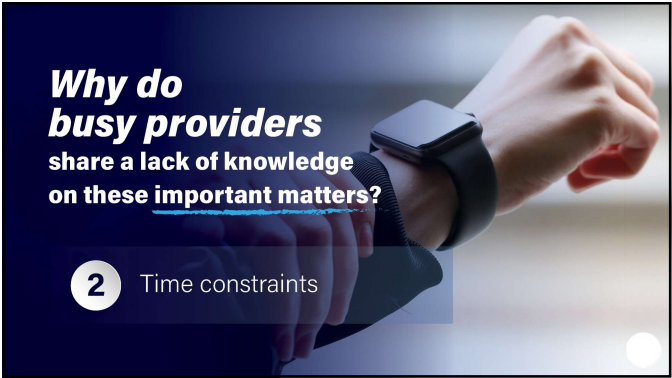
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6

Why do busy providers share a lack of knowledge on these important matters?

3 Complexity of data



7

Why do busy providers share a lack of knowledge on these important matters?

4 Perception of role



8

Why do busy providers share a lack of knowledge on these important matters?

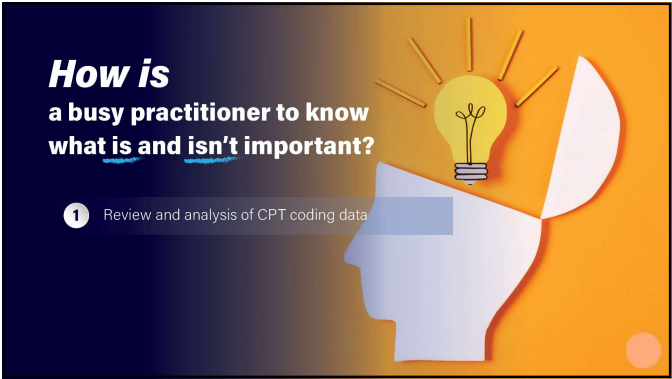
5 Lack of resources



9

How is a busy practitioner to know what is and isn't important?

1 Review and analysis of CPT coding data

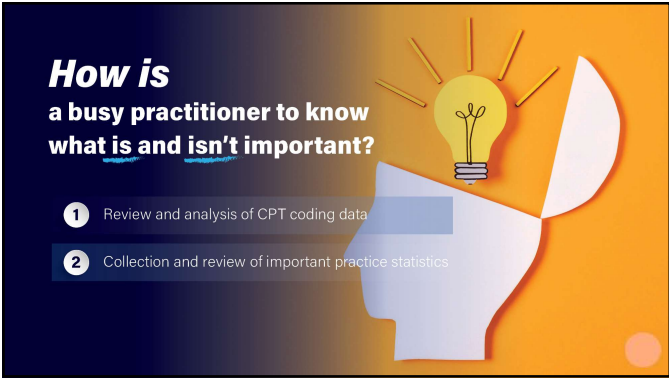


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How is a busy practitioner to know what is and isn't important?

1 Review and analysis of CPT coding data

2 Collection and review of important practice statistics



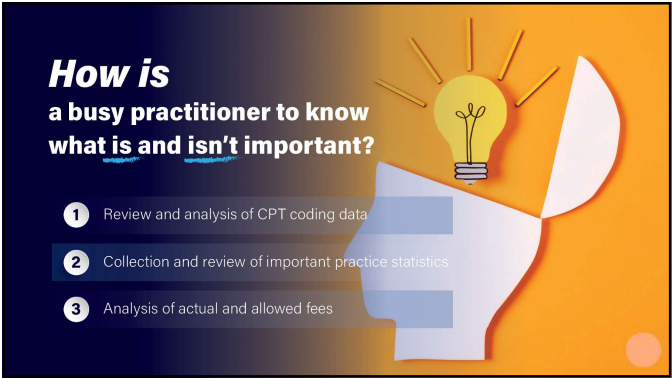
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How is a busy practitioner to know what is and isn't important?

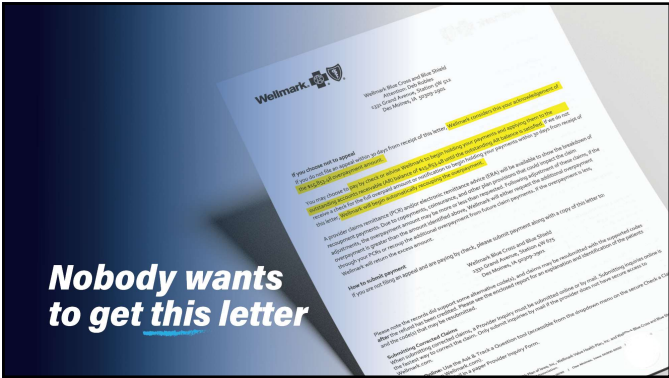
1 Review and analysis of CPT coding data

2 Collection and review of important practice statistics

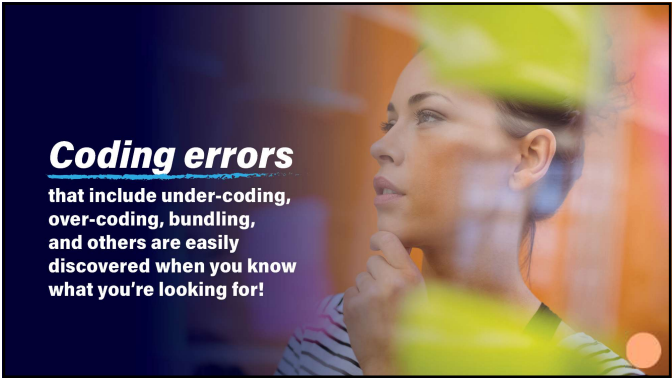
3 Analysis of actual and allowed fees



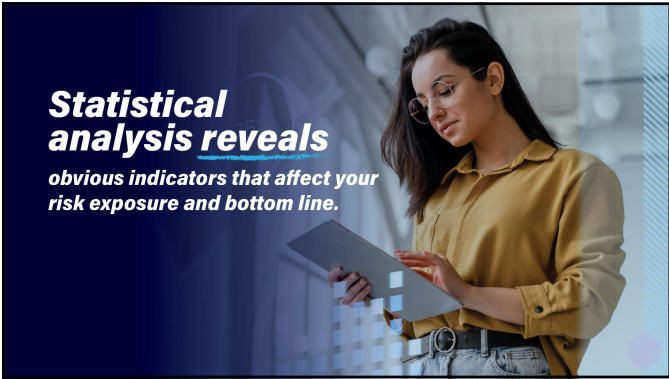
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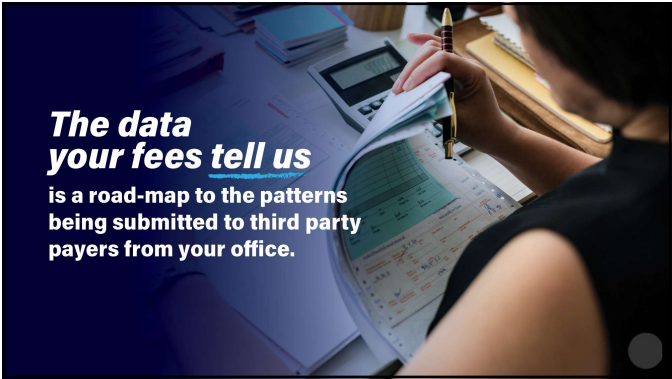
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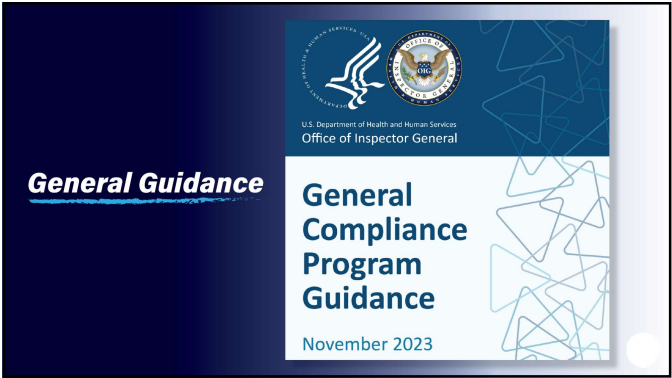
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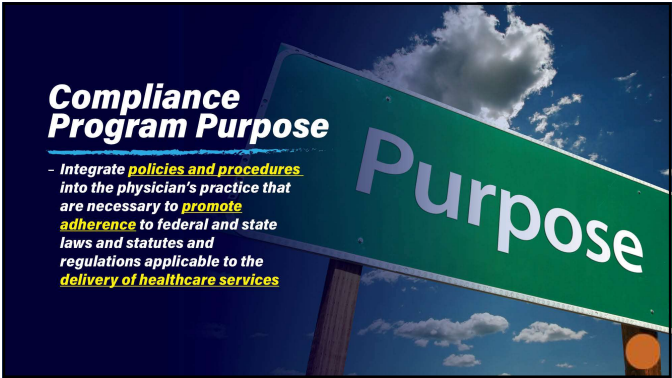
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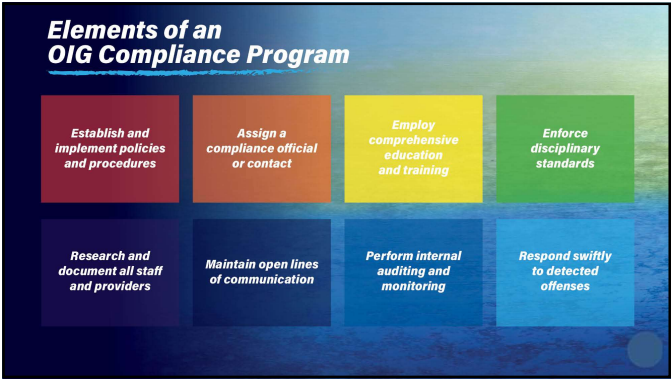
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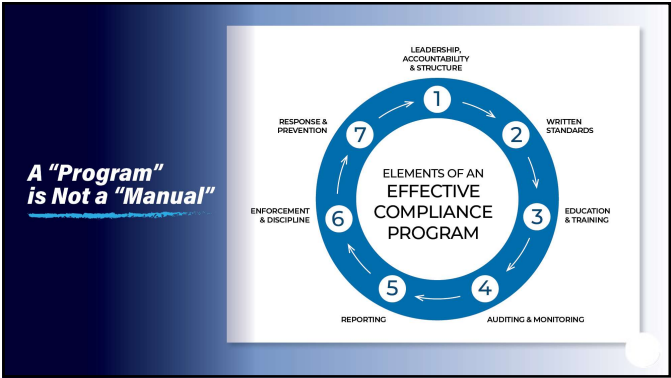
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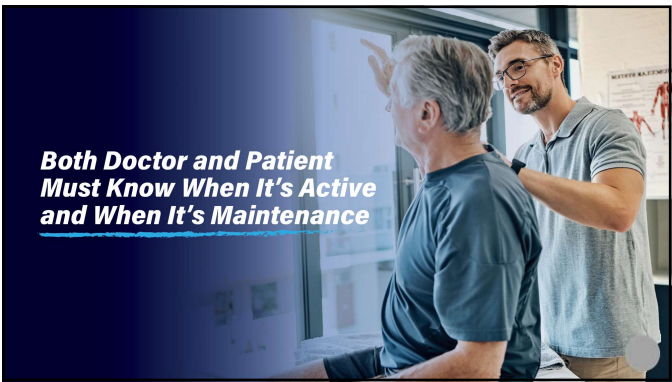
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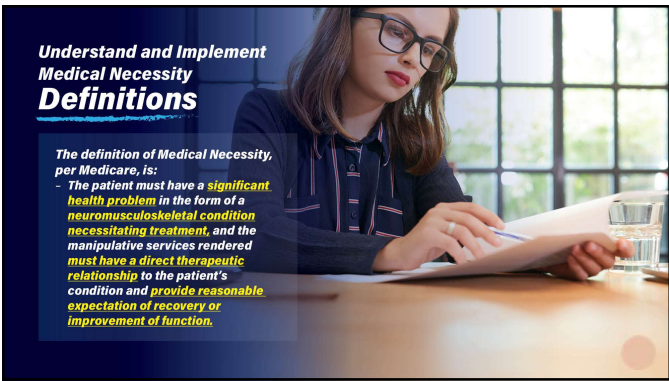
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30

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).

31

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

32

Risk #2

33

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

34

Good Documentation Tells a Story

35

Your Patient's Flow Under Care

36

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?



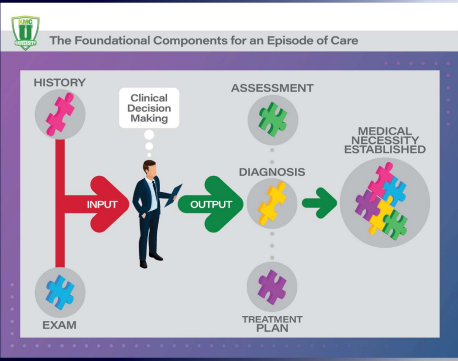
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Episodes of Care



38

The Foundational Components for an Episode of Care



39

Episodes of Care



40

Active Episodes of Care

Expect Payment from Payer



41

Medicare Documentation Guidelines in the Absence of Others

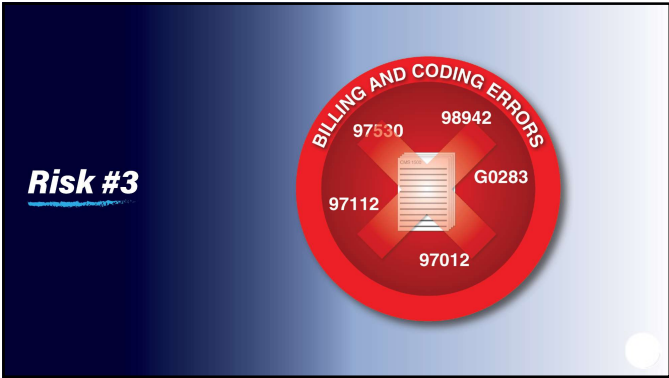
Initial Visit

- 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

42



Risk #3

43



The Regulations

44



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
- Misconducting experimental services to gain coverage

45



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.

46



Bad flags and good flags

47



CPT Coding:
Potential for **risk** AND **opportunity**

48



49



50

Evaluation and Management (E/M) Coding

	Total	Total by Category	Ratios by Category
Evaluation & Management			
99201	2	755	0.26%
99202	353		46.75%
99203	400		52.98%
99204	0		0.00%
99205	0	834	0.00%
99211	115		13.79%
99212	599		71.82%
99213	120		14.39%
99214	0		0.00%
99215	0		0.00%

51

Evaluation and Management (E/M) Coding

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99205	0	834	0.00%
99211	115		13.79%
99212	599		71.82%
99213	120		14.39%
99214	0		0.00%
99215	0		0.00%

52

	Total	Total by Category	Ratios by Category
Chiropractic Manipulation			
98940	1538	16886	9.11%
98941	15348		90.89%
98942	0		0.00%
98943	6789	6789	40.20%
S8990	6573	6573	38.93%

53

	Total	Total by Category	Ratios by Category
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55

Common Billing Errors

14 Enter one continuous 8 digit number (NPI/MDCCY) without spaces for Items 14, 16, 18, 19 and 24a

24B Enter the two digit Place of Service Code (not to be found at www.cms.gov) Example: Office-11

21 Enter diagnosis and applicable ICD indicator: 0 for ICD-10

19 Refer to public or private payer regarding the use of this field. Some payers ask for certain identifiers in this field.

22 If resubmitting a claim, enter the bill frequency code: 7 (Replacement of prior claim, & Void/cancel of prior claim. Leave blank for Medicare.)

24G Enter the number of units.

24J The individual rendering the service is reported in 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.

24E Enter the diagnosis pointer from field 21 to link a diagnosis code to the CPT performed.

24A Enter the number of the individual rendering the service is reported in 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.

24C Enter the NPI number of the individual rendering the service is reported in 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.

56

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Risk #4

PATIENT FINANCIAL INCONSISTENCIES

58

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

ACTUAL FEES
Actual fees are the provider's highest, undiscounted fee schedule. They are the amount you bill your patients. All discounts are taken from actual fees.

DISCOUNTED FEES
Discounted fees are the provider's discounted fee schedule. They are the amount you bill your patients after discounts are applied. They are the amount you bill your patients after discounts are applied.

IMPOSED DISCOUNTS
Regulated discounts include those fees which you must accept because they are regulated by a governing body. Contractual discounts are those prices agreed to by contract for delivery of the services. Regulated discounts include: Medicare, Medicaid, Veterans Affairs, and other government programs. Contractual discounts include: Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), and other managed care contracts.

ELECTIVE DISCOUNTS
Elective discounts are those fees which you may choose to discount at your discretion. They are the amount you bill your patients after discounts are applied. They are the amount you bill your patients after discounts are applied. Elective discounts include: Charity discounts, prompt payment discounts, and other discounts that are not regulated by a governing body.

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Avoid Dual Fee Schedules

Charging insurance companies more than cash patients

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

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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



61

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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Red Flags for Chiropractors

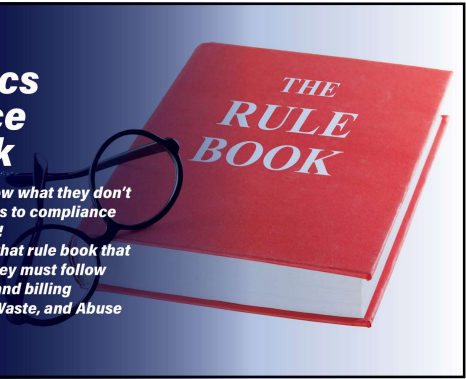
- Medicare claim data
- Spinal CMT Coding percentage
- Beneficiary Complaints



63

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



64

You're Going to Find Some Things Wrong



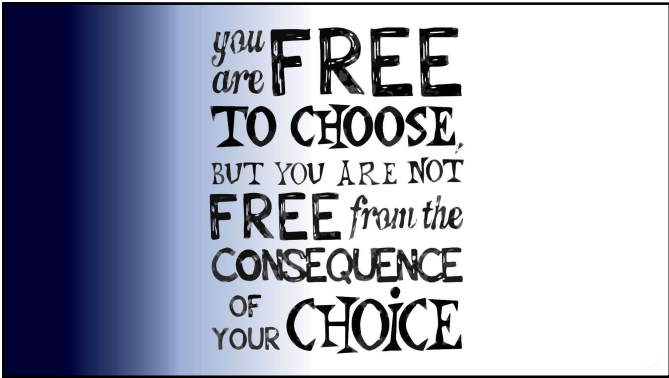
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Start an "Issues List"

- 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



66



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