
KMC
U
UNIVERSITY
OIG Compliance:
Why Should I Care?
Presented by:
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Continuing Education Information
States Eligible for PACE Continuing Education Credits
The following states offer CE credits for at this event

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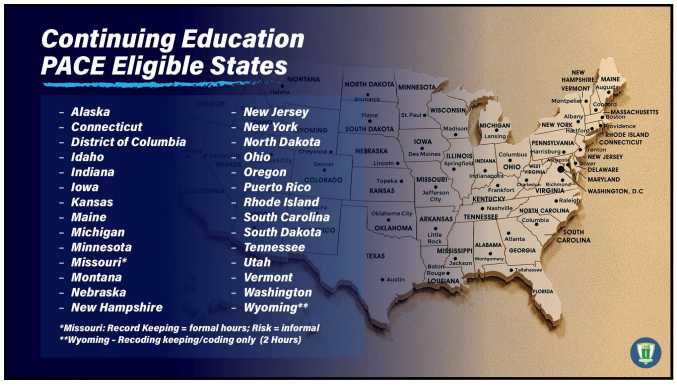
Continuing Education
PACE Eligible States
- Alaska
- Connecticut
- District of Columbia
- Idaho
- Indiana
- Iowa
- Kansas
- Maine
- Michigan
- Minnesota
- Missouri*
- Montana
- Nebraska
- New Hampshire
- New Jersey
- New York
- North Dakota
- Ohio
- Oregon
- Puerto Rico
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Utah
- Vermont
- Washington
- Wyoming**
*Missouri: Record Keeping = formal hours; Risk = informal
**Wyoming - Recoding keeping/coding only (2 Hours)

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Steps to Obtain CE Credits
step
by
step
Follow these simple steps below:
- Fill out the CE certificate
- Return it to KMC representative
- KMCU to submit to Pace for approval
- You will receive your certificate via email

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Today's Objectives
Identify
Identify the OIG regulations and oversight that apply to chiropractors and their teams
Recognize
Recognize the risk factors that regulators look for in an audit
Develop
Develop an action list to begin implementing an OIG Compliance Program for your clinic
Apply
Apply the seven elements of a compliance program to your practice

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Please Note!
- The views and opinions expressed in this presentation are solely those of the author, Kathy Weidner
- Kathy and/or KMC University does not set practice standards
- We offer this only to educate and inform
- Medicare information provided today is available in the public domain

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Know the Messenger, Hear the Message
- 42 years serving the Chiropractic profession
- American Chiropractic Association 1999-2001
- Founded KMC University 2007
- Medical Compliance Specialist-Physician (MCS-P) 2011
- Certified Professional Chiropractic Coder (CCPC) 2015
- Certified Professional Compliance Officer (CPCO) 2022

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COMPLIANCE
CONTROL
LAWS
RULES
RISK
STRATEGY
MEDICARE
AUDIT
SOAP NOTES
INSURANCE
CODING
HIPAA

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Know the Messenger, Hear the Message
- Second generation chiropractor
- Practiced for over 20 years
- Completed 100 hour Insurance Consultant/Peer Review Certification
- Medical Compliance Specialist-Physician (MCS-P) 2016
- Joined KMC University 2020
- Certified Professional Medical Auditor (CPMA) 2022
- Director of Education 2024
- Certified Professional Compliance Officer (CPCO) 2024

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OIG Audit Experience
REQUEST FOR INFORMATION

10


OIG Audit Experience
- Received initial announcement letter requesting 5 charts
- Submitted the requested charts
- Received a Denial Letter

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OIG Audit Experience
- In-Office Interview and Records Request for an additional 100 charts
- Requested a copy of the practice's written compliance program
- Audited over two calendar years' worth of dates of service
OFFICE OF INSPECTOR GENERAL
SPECIAL AGENT

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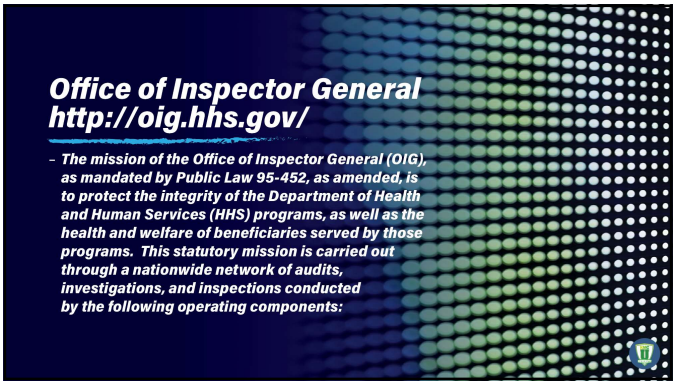

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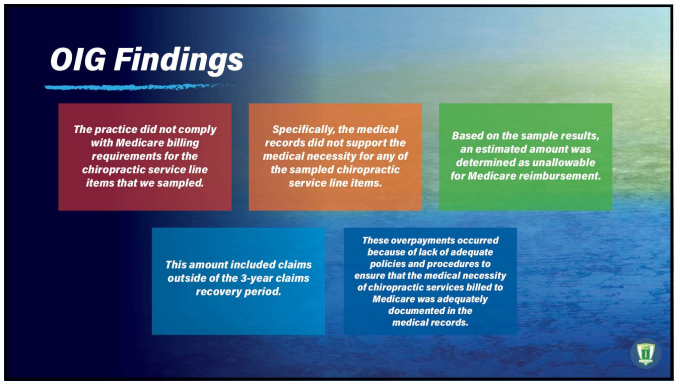

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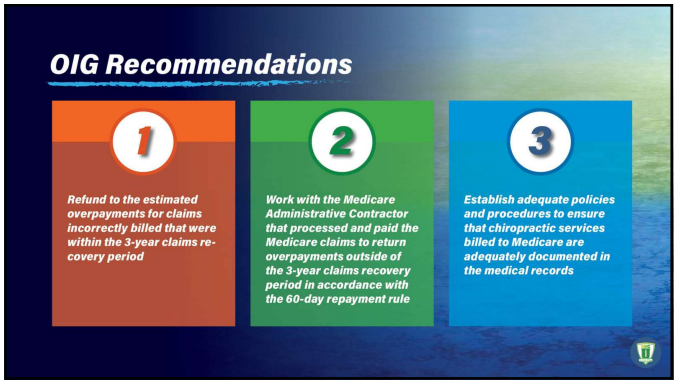

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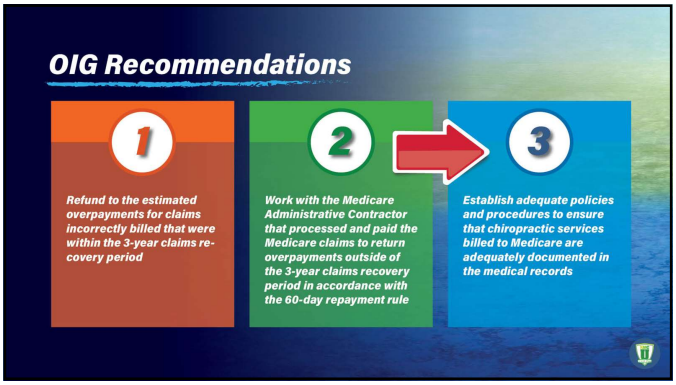

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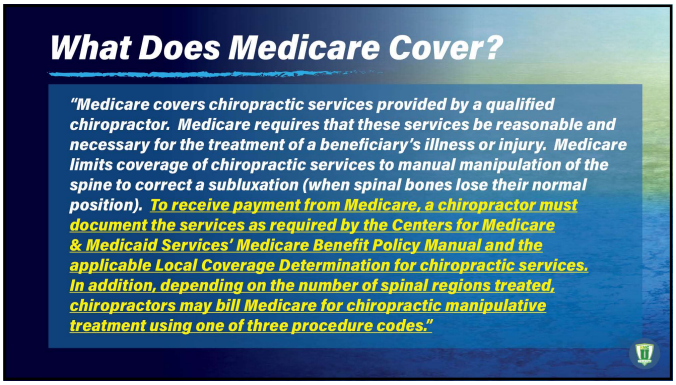

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Chiropractic Services

- The most common therapeutic procedure performed by chiropractors is known as spinal manipulation, also called chiropractic adjustment. The purpose of spinal manipulation is to restore joint mobility by manually applying a controlled force into joints that have become restricted in their movement as a result of a tissue injury. When other medical conditions exist, chiropractic care may complement or support medical treatment.

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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)5 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).

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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 n 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

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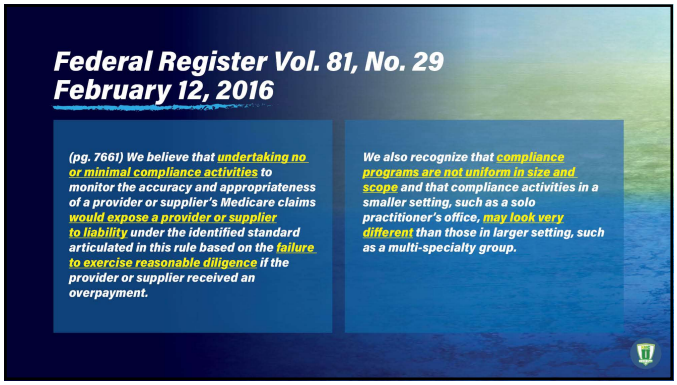

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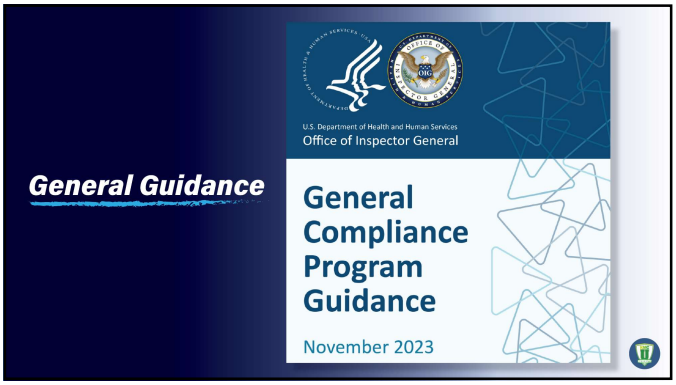

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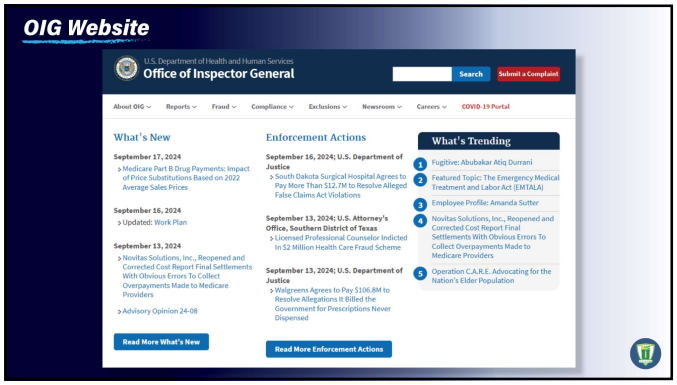

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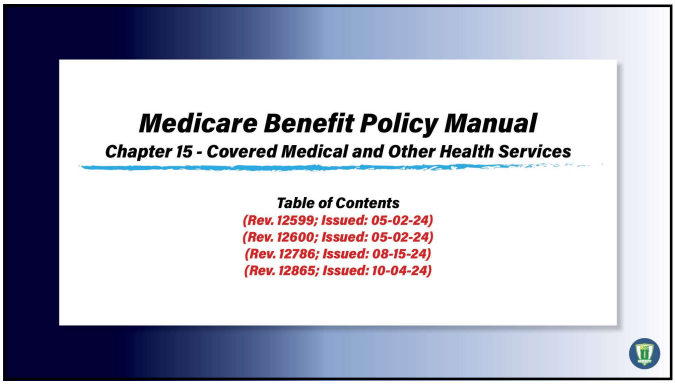

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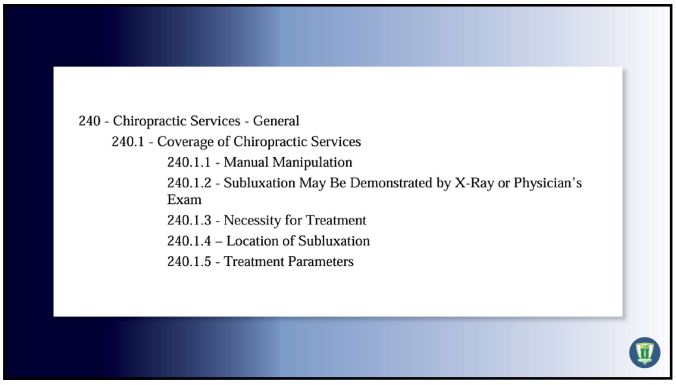

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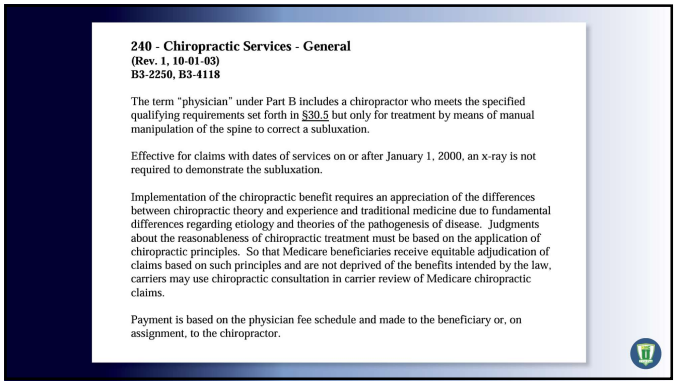

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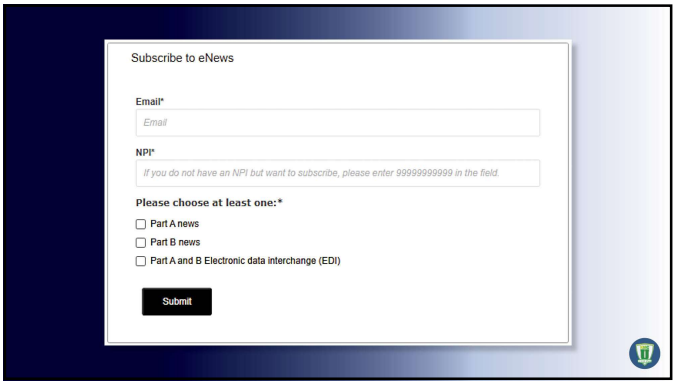

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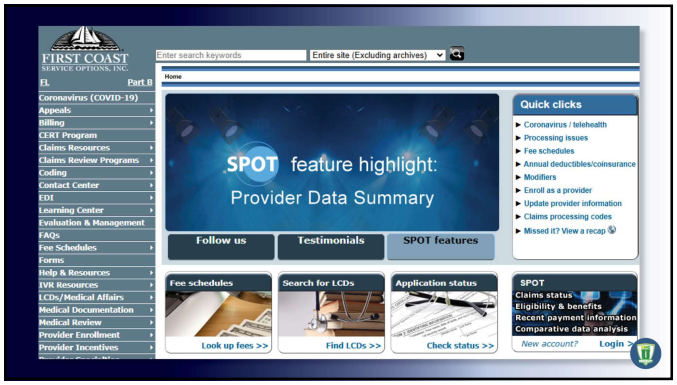

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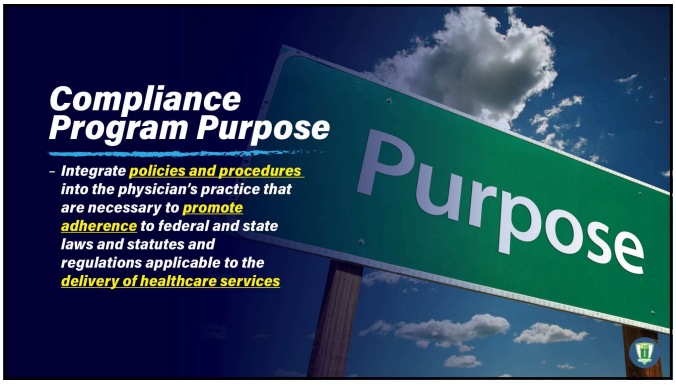

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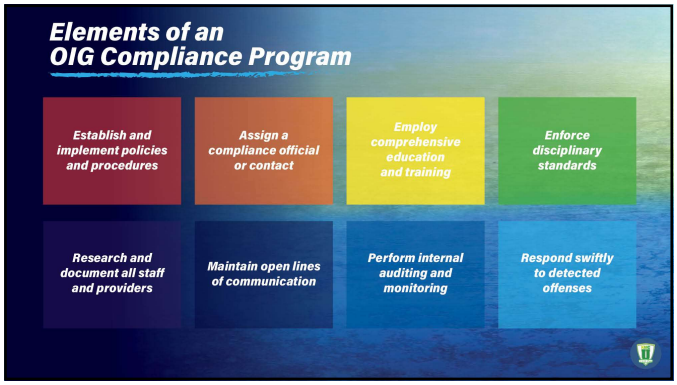

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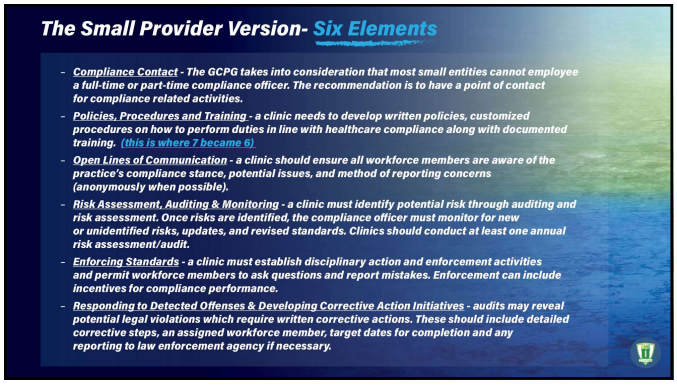

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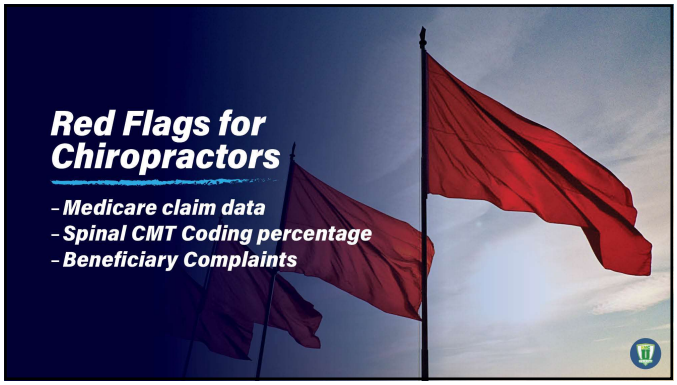

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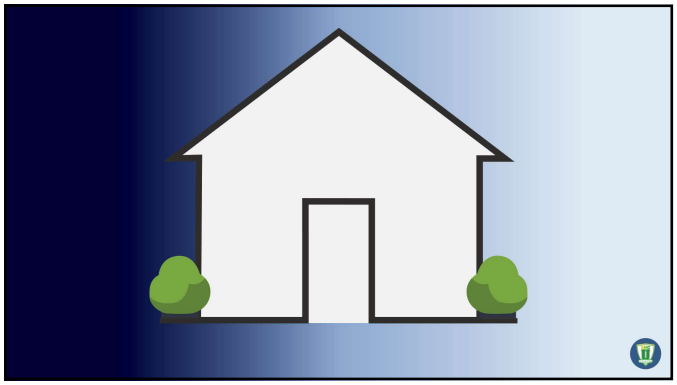

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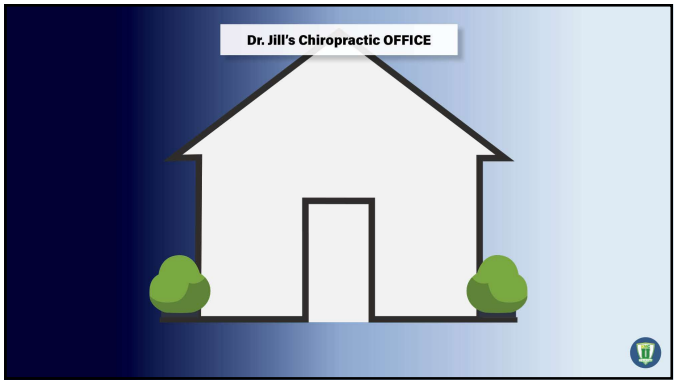

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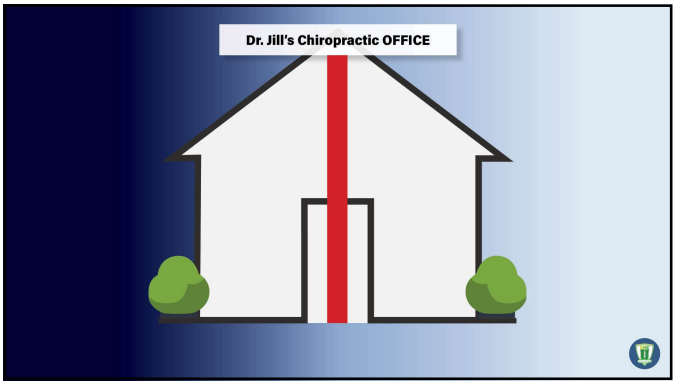

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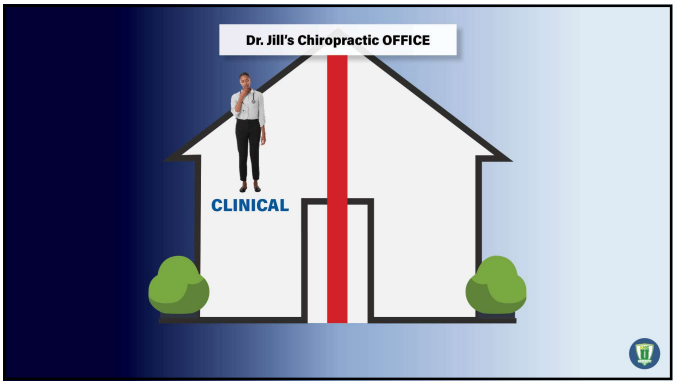

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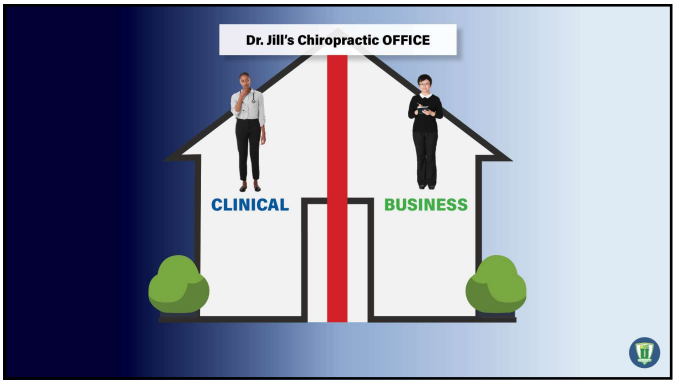

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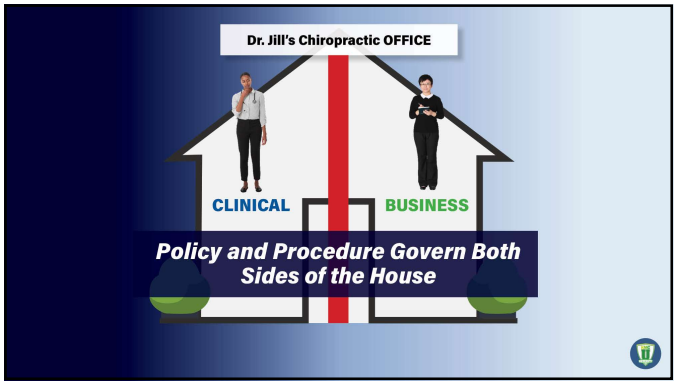

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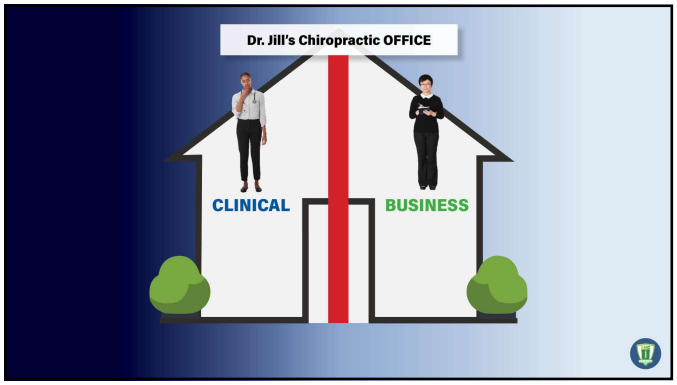

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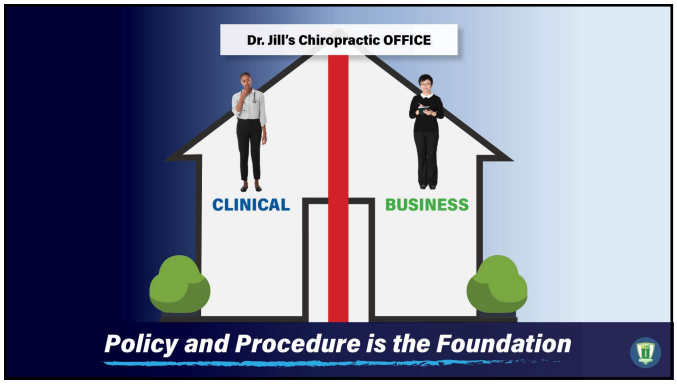

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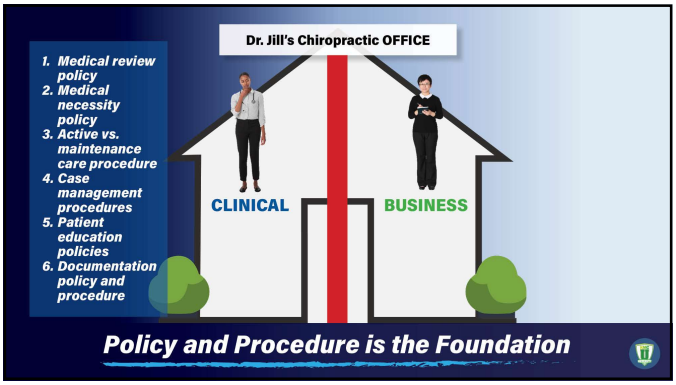

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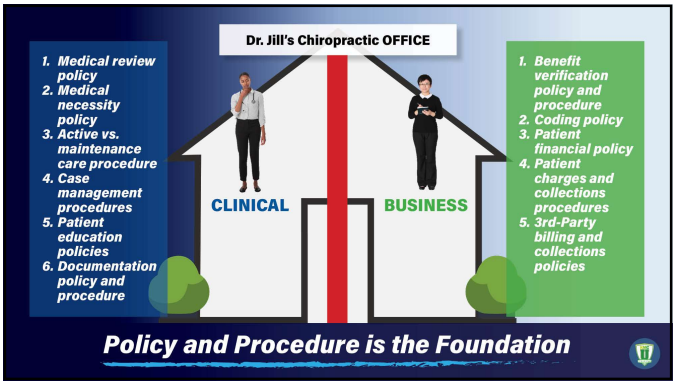

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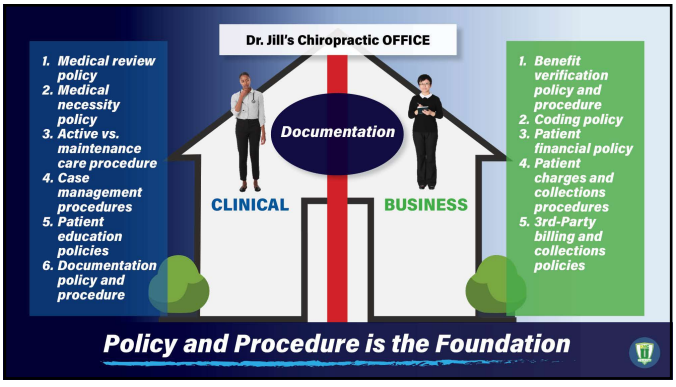

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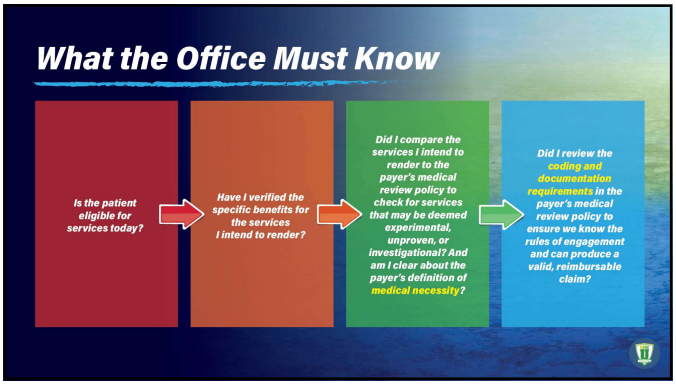

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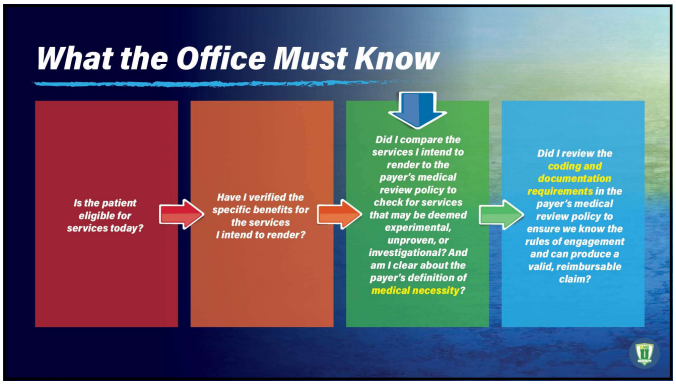

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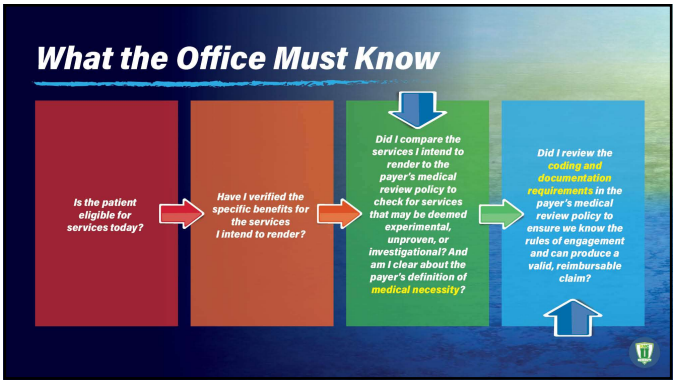

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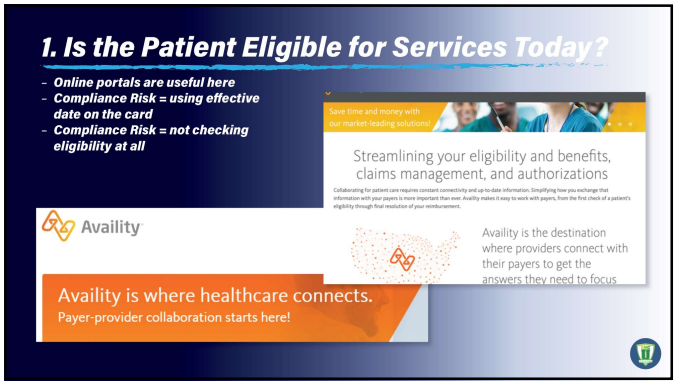

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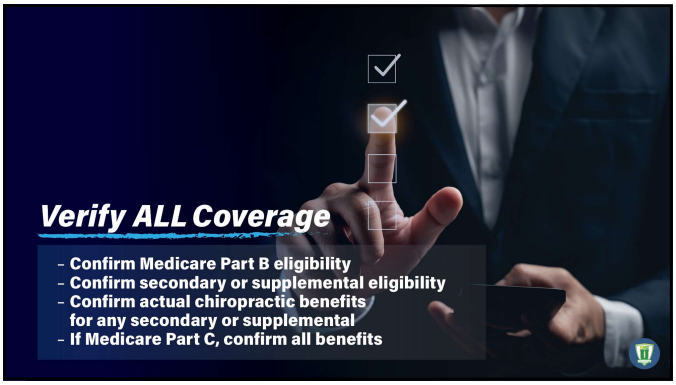

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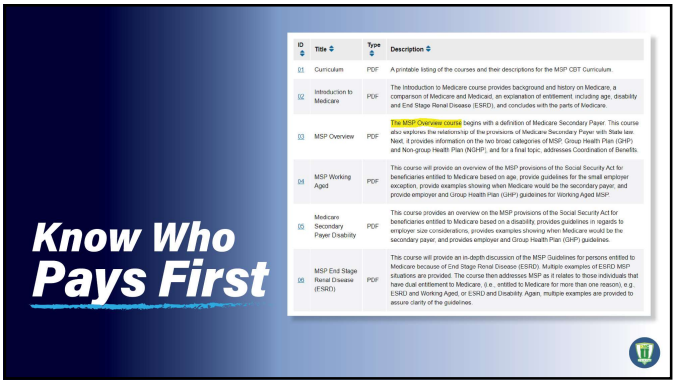

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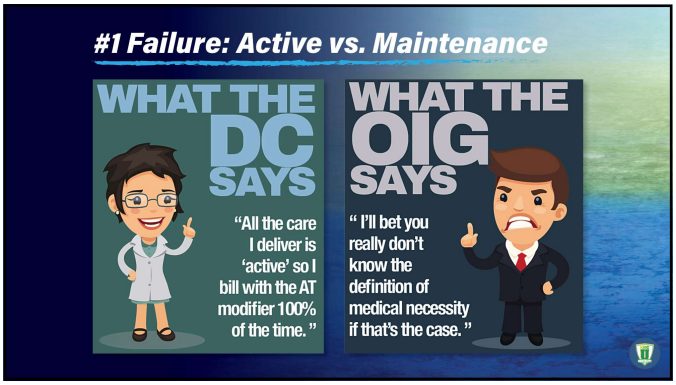

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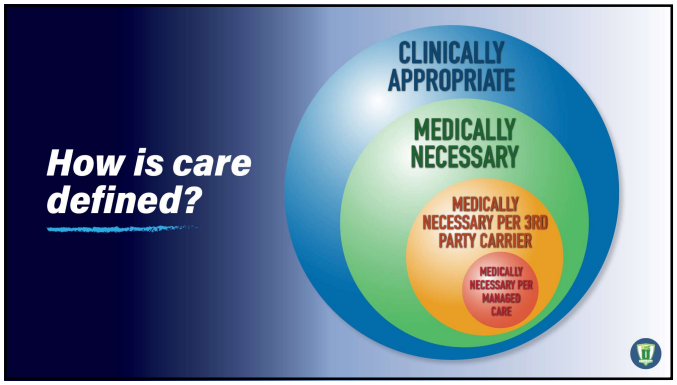

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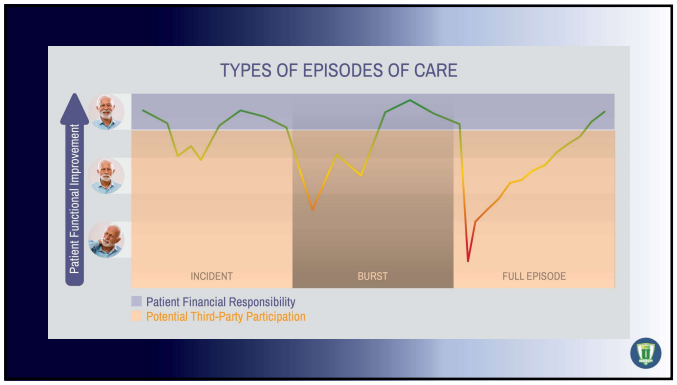

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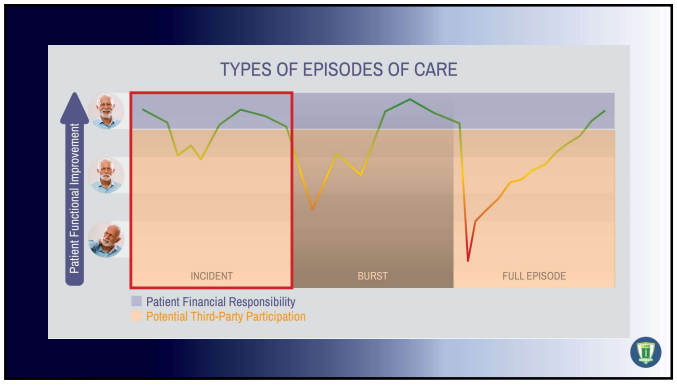

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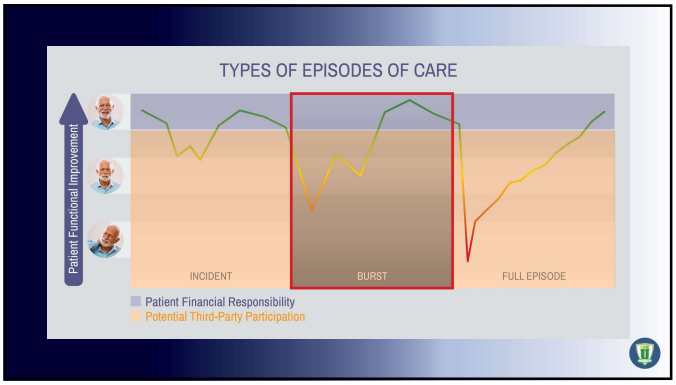

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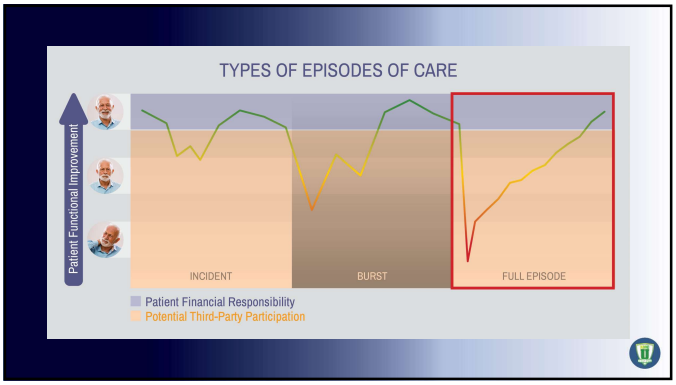

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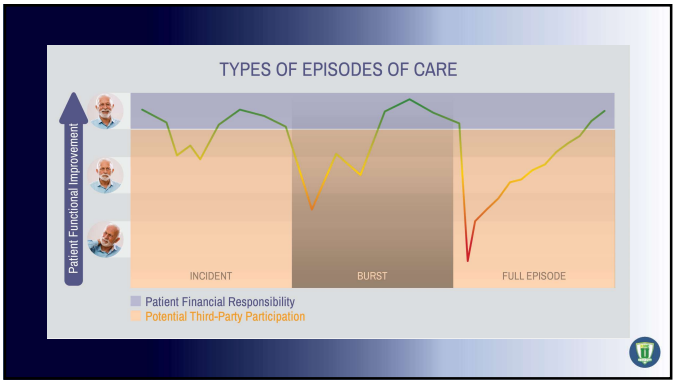

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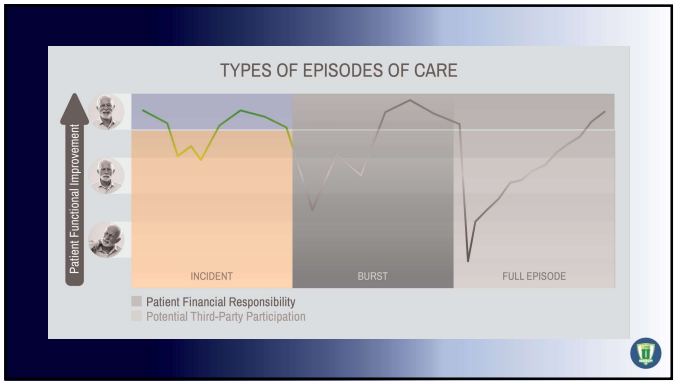

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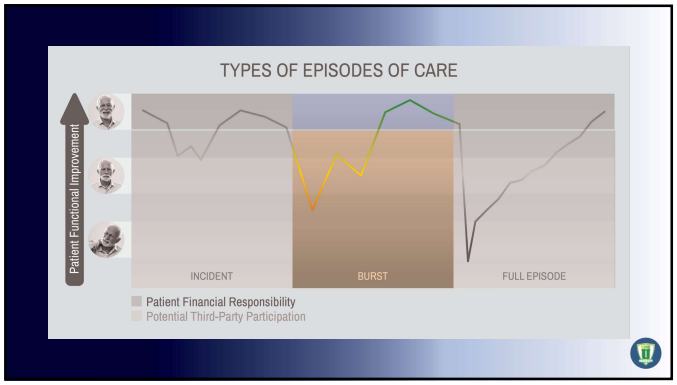

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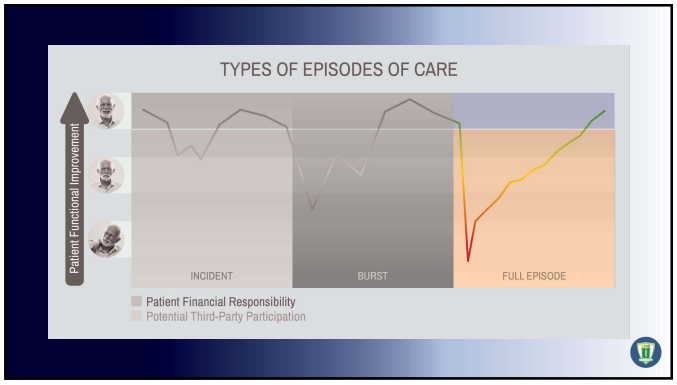

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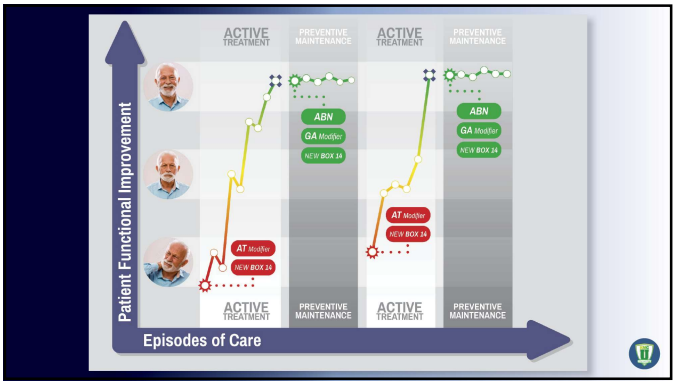

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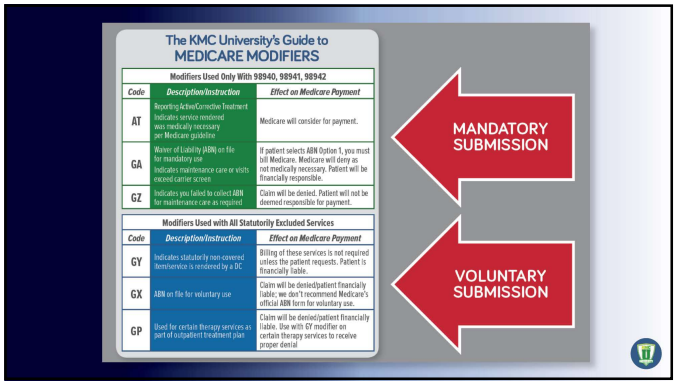

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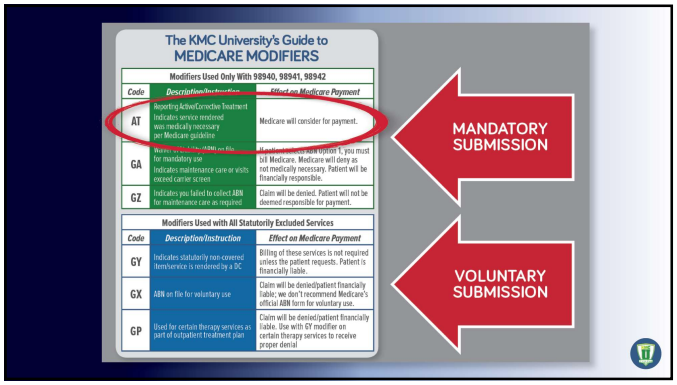

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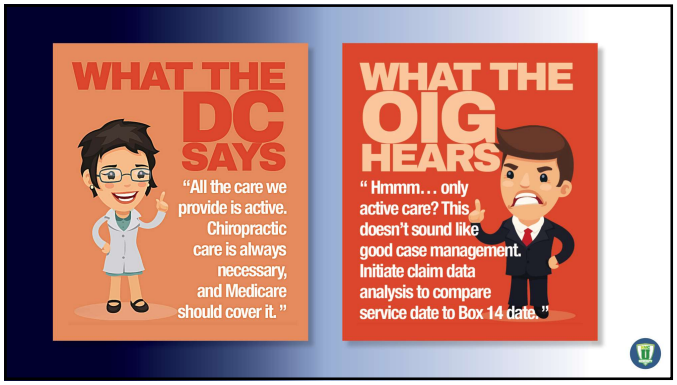

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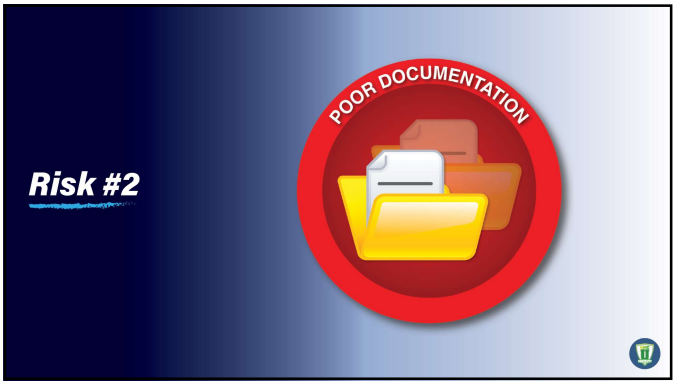

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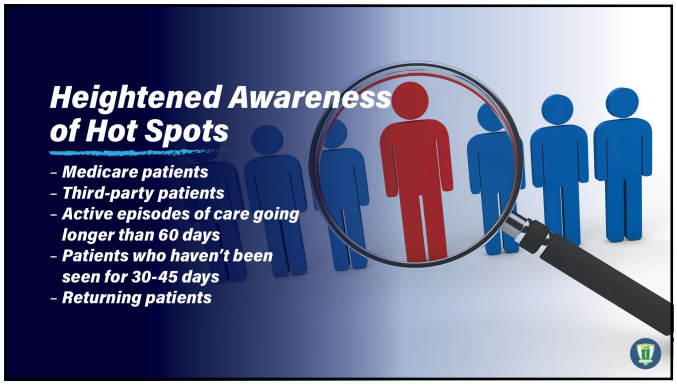

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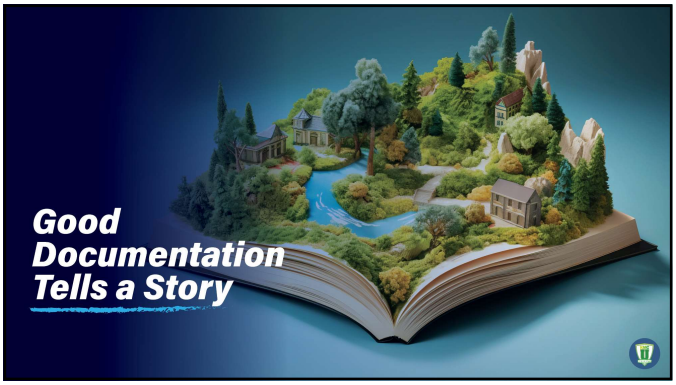

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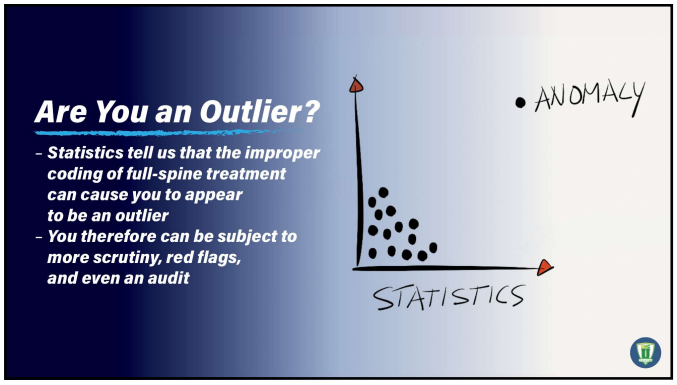

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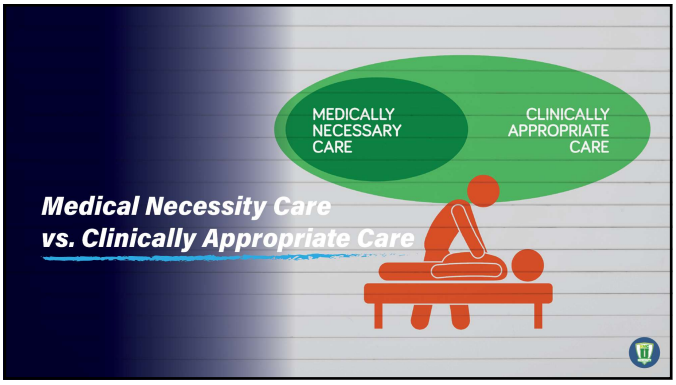

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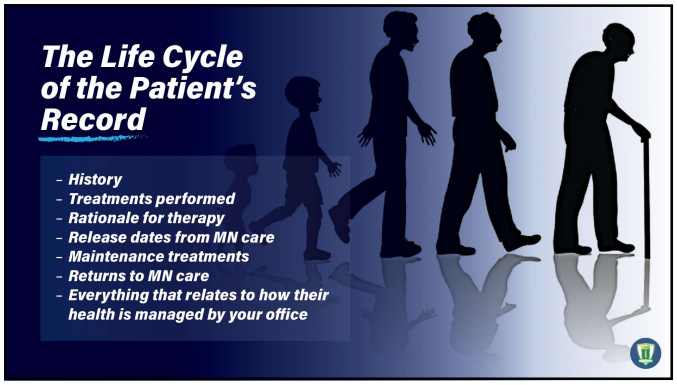

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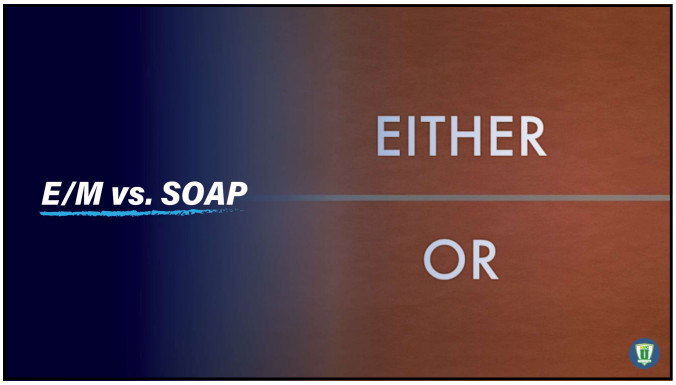

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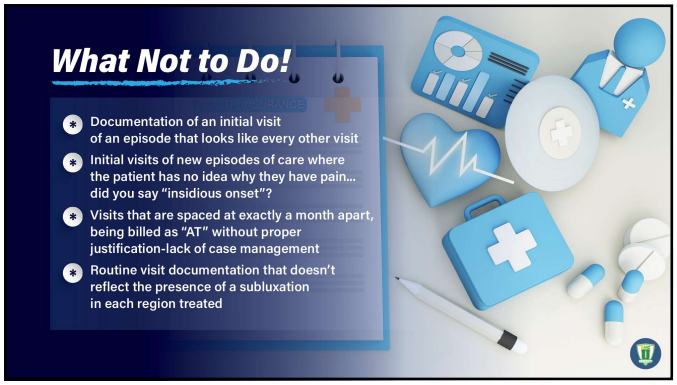

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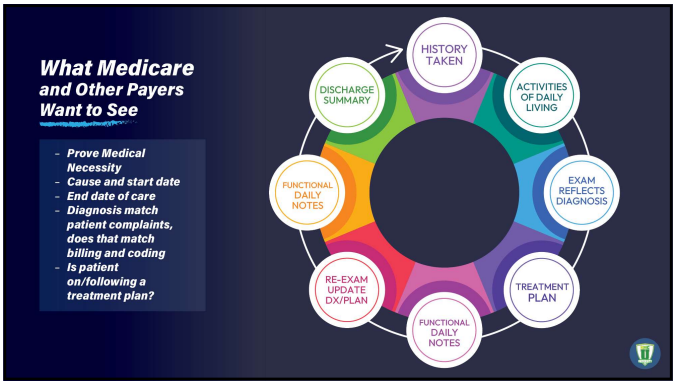

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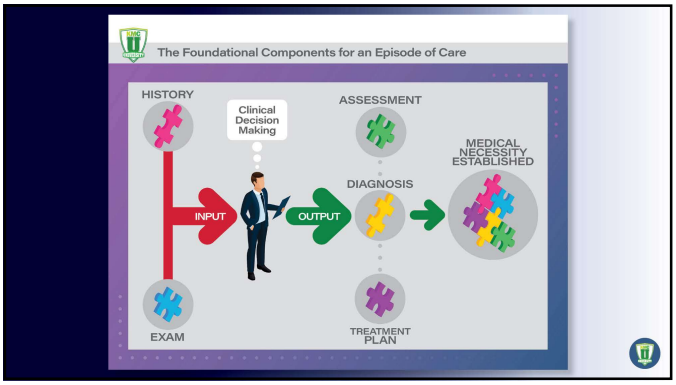

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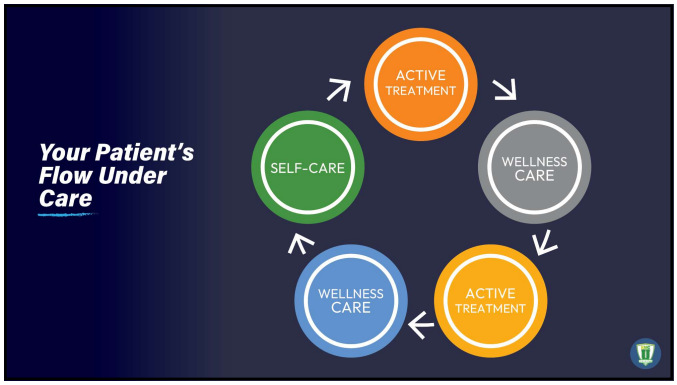

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Medicare Documentation Guidelines in the Absence of Others

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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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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Is the condition likely to be treated as an INCIDENT, BURST or EPISODE?

KMC University's classification of treatment lengths for active treatment are described as incidents, bursts, and episodes. Follow these cues to verify that your documentation is sufficient to warrant the level of recommended care.

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?

NO → In this circumstance, per Medicare coverage requirements, medical necessity cannot be established and therefore the condition is likely maintenance care.

YES

CONSIDER: Will the condition likely be resolved within 1-3 visits? NO → **CONSIDER:** Will the condition likely be resolved within about a month? NO → **CONSIDER:** Will the condition likely require treatment beyond a month?

YES → **DOCUMENT:**
- History/Chief Complaint
- Mechanism of injury
- DATS if last score was > 30 days old
- Exam/Physical findings/PART
- DX: Seg. Dys. + 2ndary condition per region treated
- Measurable functional deficits
- TX Plan including goals, and estimated discharge

Formal E/M service **may not be necessary.** Documentation within CMT may be possible.

Incident

YES → **DOCUMENT:**
- History/Chief Complaint
- Mechanism of injury
- DATs result and score
- Exam/Physical findings/PART
- DX: Seg. Dys. + 2ndary condition per region treated
- Measurable functional deficits
- TX plan, including STG&TG
- Estimated discharge or re-evaluation date

Formal E/M service **necessary** to establish medical necessity for this much care.

Burst

YES → **DOCUMENT:**
- History/Chief Complaint
- Mechanism of injury
- DATs result and score
- Exam/Physical findings/PART
- DX: Seg. Dys. + 2ndary condition per region treated
- Measurable functional deficits
- TX Plan including goals
- Date of next re-evaluation (re-evals at least every 30 days)

Formal E/M service **necessary** to establish medical necessity for this much care.

Episode

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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/Percussion** Positive upon palpation at L2-5, 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 pelvis region

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An Incident-Within SOAP Documentation

Assessment:
Fred has suffered a reoccurrence of lower back pain after his trip and fall. He has been treated for these conditions previously in this office and based on my knowledge of his case, I see no reason that he won't progress well from this setback. The multiple exacerbations 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: (M99.03) Seg and somatic dysf. of lumbar reg. (M54.5) Lumbalgia, (M99.04) Seg and somatic dysf. of sacral reg; (S33.6XXA) Sprain of SI joint, Initial Encounter, (M99.05) Seg 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 level(s) 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 level(s)

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Risk #3

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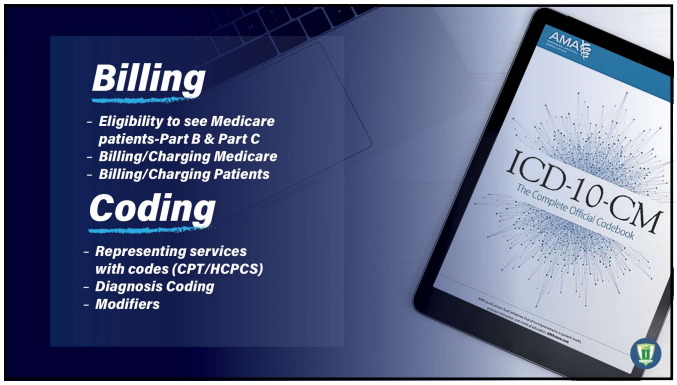

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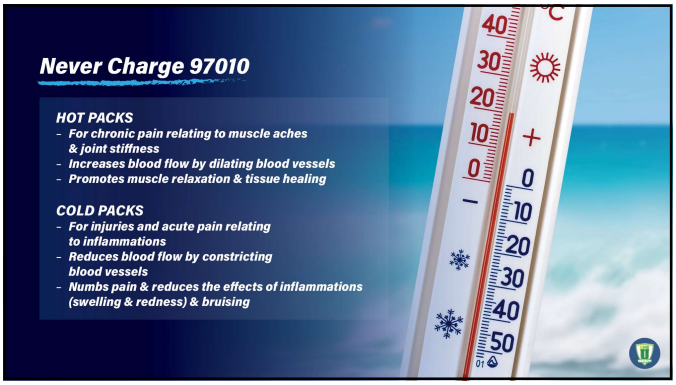

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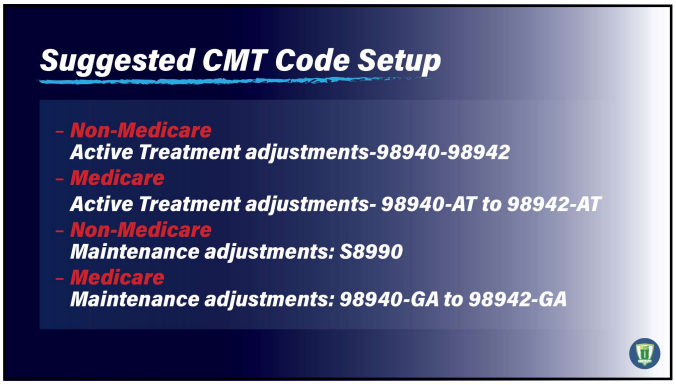

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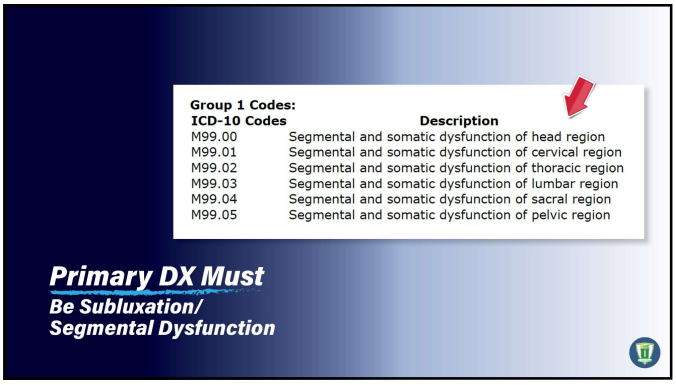

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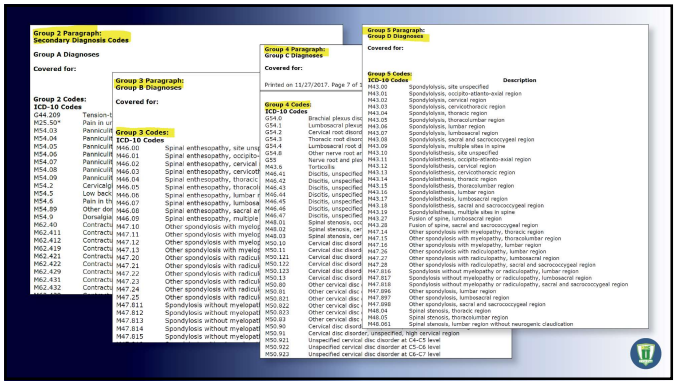

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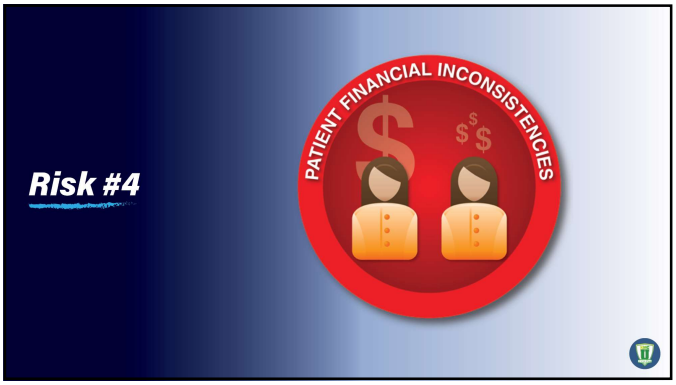

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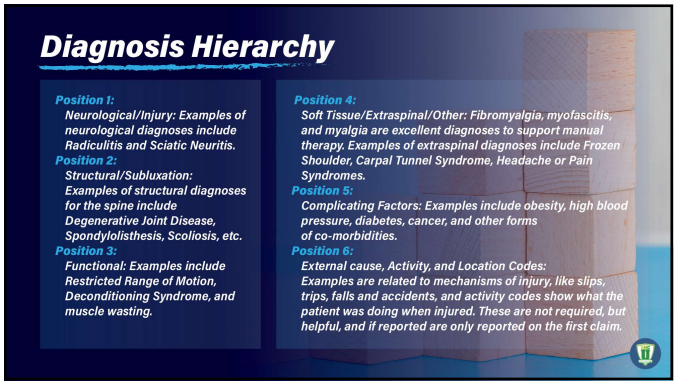

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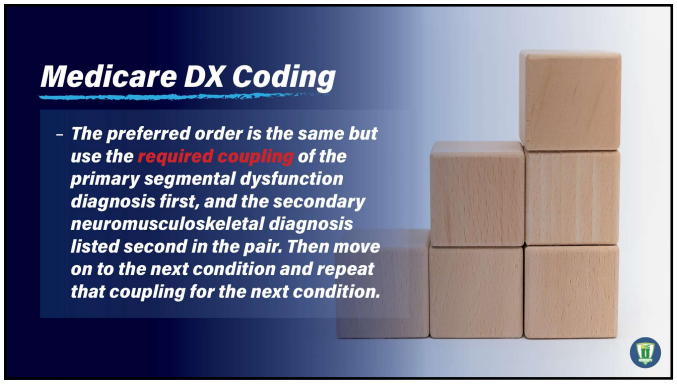

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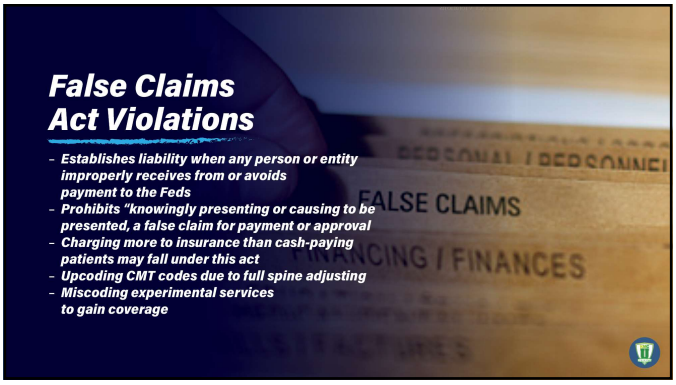

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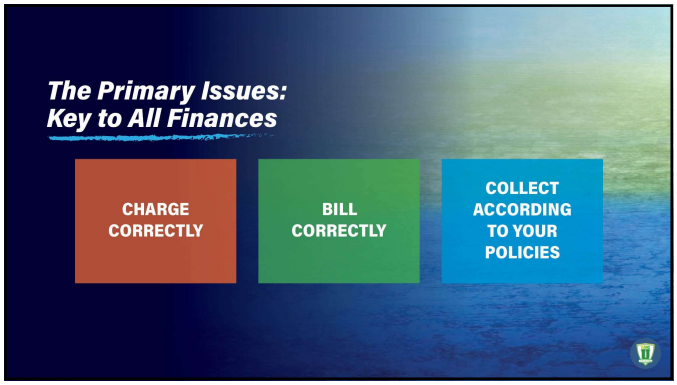

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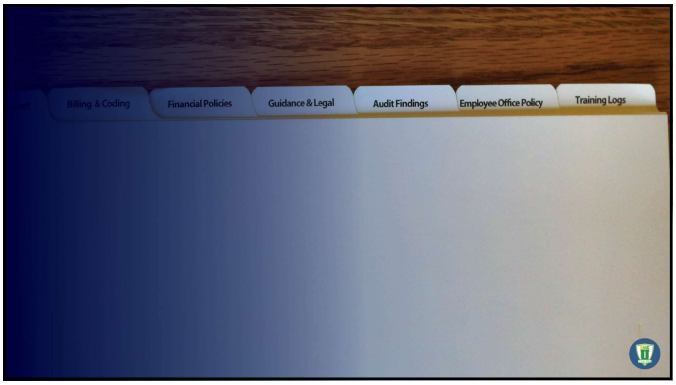

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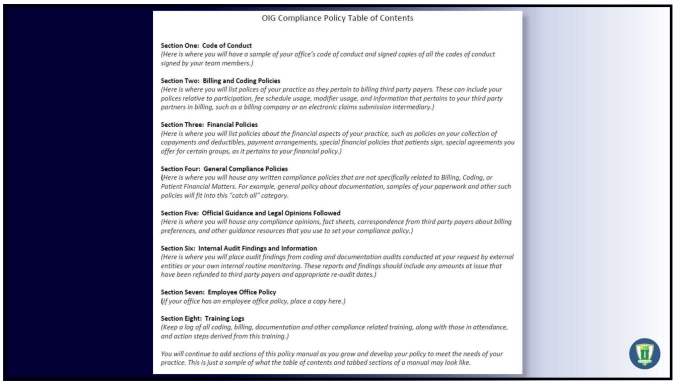

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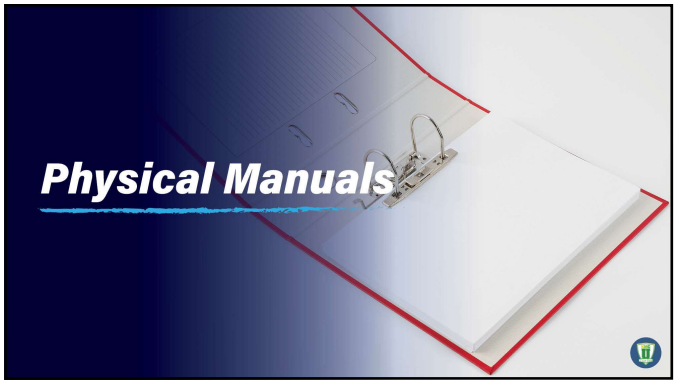

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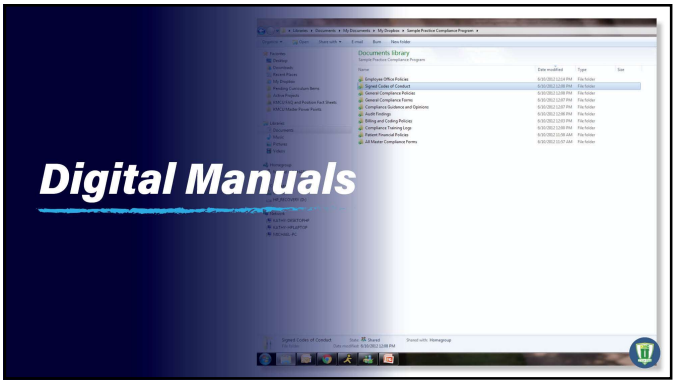

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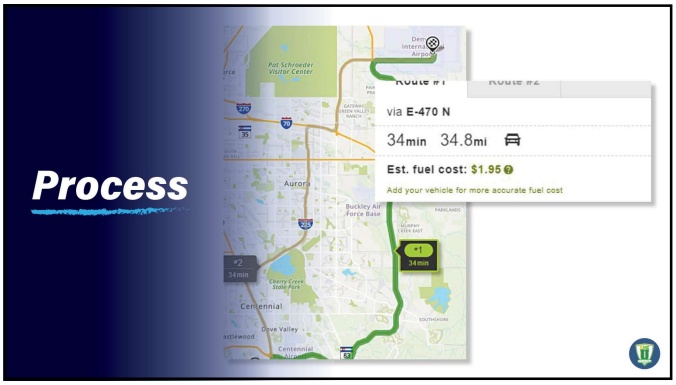

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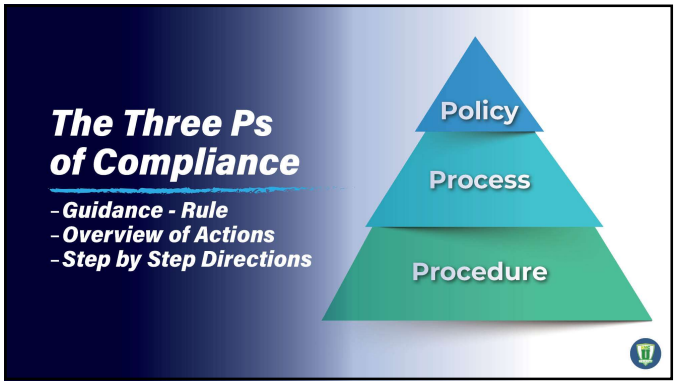

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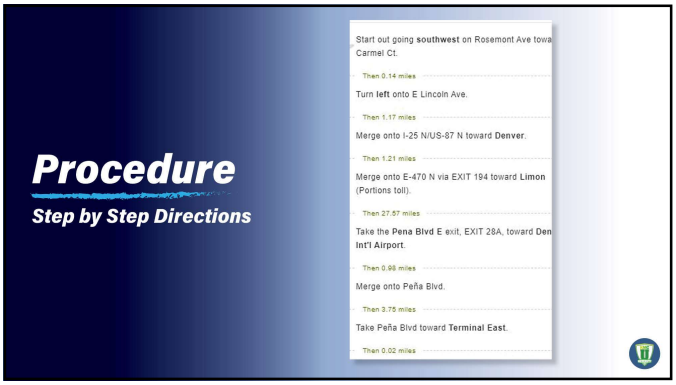

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What is the Difference?

Policies

- A Policy is a predetermined course of action, which is established to provide a guide toward accepted business strategies and objectives as well as compliantly operating

Procedures

- A procedure is a fixed, step-by-step sequence of activities or course of action (with definite start and end points) that must be followed in the same order to correctly perform a task
- Procedures provide the reader with a clear and easily-understood plan of action required to carry out or implement a policy

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Policy

Are general in nature	Identify company rules	Explain why the rule exists	Tell when the rule applies
Describe who it covers	What & Why	Describe the consequences	Are normally described using simple sentences and paragraphs

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Procedure

Identify specific actions	Explain when to take actions	Describe alternatives	Show emergency procedures
Include warnings and cautions	Examples included	How, When & Who	Are normally written using an outline format

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A Winning Combination

- Procedures are the specific methods employed to express policies in action in day-to-day operations of the organization
- Together, policies and procedures ensure a point of view held by the practice is translated into steps that result in an outcome compatible with that view

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Implement Policies and Procedures

- Assess what policy and procedure exists
- Make an action list of the most important policies first
- Documentation, Medicare, Financial, and Coding policies take precedent
- Similar to HIPAA in that both require P&P customized and scaled to practice

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Policy Can Defend in a Billing Error

(Practice Identifying Information)

Sample Office Policy for:

Counting & Billing Timed Treatment Codes

It is the policy of this office to always document and code properly to ensure that only that care which is medically necessary is presented for payment from a third party payer. To that end, we recognize that we must clearly describe the appropriate amount of intra-service time spent with the patient for documentation, coding, and billing purposes.

This office follows the guidance from the AMA/CPT and CMS when determining the timed coding processes used. It is our policy to never charge for a timed treatment code performed for less than 8 minutes. We will properly document the service in the patient's record, but will not charge for the service if it doesn't meet the appropriate time threshold. We review carrier medical review policy for the carriers we bill on a regular basis to determine whether their specific policy is different from that of the AMA/CPT process. If so, we will ensure that we bill for timed codes according to the policy of the carrier we're billing. Through our internal documentation and coding auditing processes, we regularly review and evaluate our timed coding billing. This policy will be reviewed at least annually and updated as necessary.

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Policies for Each Organization

- OIG (Office of Inspector General) requires policies for healthcare operations
- OCR (Office of Civil Rights) requires polices for HIPAA (privacy)
- State Boards may require standards or rules that require a policy
- 3rd Party payers may require standards or rules that require policies or different paperwork than what is normally used in your office… you need policy for this!

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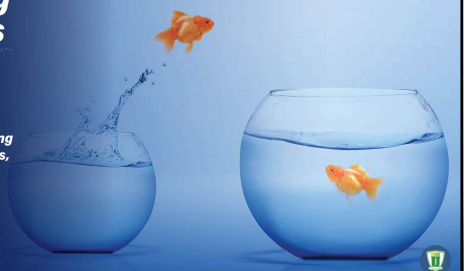
Conflicting Guidelines

When you encounter conflicting statements (State Law vs. Federal Law on billing, coding, documentation, delegating services, medical records, etc. …
Always adhere to the most restrictive!



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State Board Rules that May Require Policy

Most states have minimum documentation requirements

- Blood pressure (1/yr., quarterly, if history indicates)
- Non-musculoskeletal history
- Service performed
- Dx
- Complaint/symptoms
- Objective findings
- Referrals, testing,

If your state has minimum requirements, you must have a policy stating how you will meet and/or exceed the requirement

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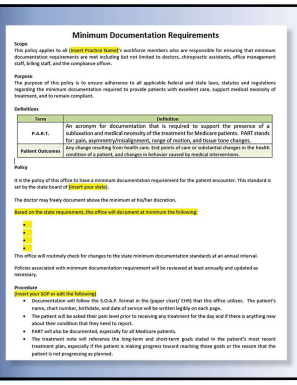
Sample Policy Example of What May be Required



Minimum Documentation Requirements

Scope

This policy applies to all {Insert Practice Name}'s workforce members who are responsible for ensuring that minimum documentation requirements are met including but not limited to doctors, chiropractic assistants, office management staff, billing staff, and the compliance officer.

Purpose

The purpose of this policy is to ensure adherence to all applicable federal and state laws, statutes and regulations regarding the minimum documentation required to provide patients with excellent care, support medical necessity of treatment, and to remain compliant.

Definitions

Term	Definition
P.A.R.T.	An acronym for documentation that is required to support the presence of a subluxation and medical necessity of the treatment for Medicare patients. PART stands for: pain, asymmetry/misalignment, range of motion, and tissue tone changes.
Patient Outcomes	Any change resulting from health care. End points of care or substantial changes in the health condition of a patient, and changes in behavior caused by medical interventions.

Policy

It is the policy of this office to have a minimum documentation requirement for the patient encounter. This standard is set by the state board of {insert your state}.

The doctor may freely document above the minimum at his/her discretion.

Based on the state requirement, this office will document at minimum the following:

- {}
- {}
- {}
- {}

This office will routinely check for changes to the state minimum documentation standards at an annual interval.

Policies associated with minimum documentation requirement will be reviewed at least annually and updated as necessary.

Procedure

{Insert also SOP or edit the following}

- Documentation will follow the S.O.A.P. format in the (paper chart/ EHR) that this office utilizes. The patient's name, chart number, birthdate, and date of service will be written legibly on each page.
- The patient will be asked their pain level prior to receiving any treatment for the day and if there is anything new about their condition that they need to report.
- PART will also be documented, especially for all Medicare patients.
- The treatment note will reference the long-term and short-term goals stated in the patient's most recent treatment plan, especially if the patient is making progress toward reaching these goals or the reason that the patient is not progressing as planned.

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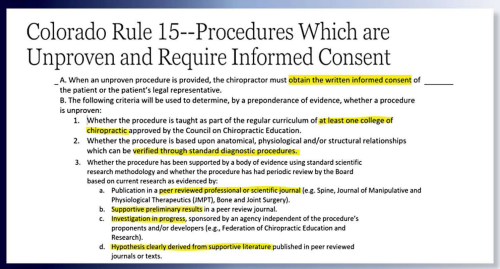
Colorado Rule 15-Procedures Which are Unproven and Require Informed Consent



Colorado Rule 15--Procedures Which are Unproven and Require Informed Consent

A. When an unproven procedure is provided, the chiropractor must obtain the written informed consent of _____ the patient or the patient's legal representative.
B. The following criteria will be used to determine, by a preponderance of evidence, whether a procedure is unproven:
1. Whether the procedure is taught as part of the regular curriculum of at least one college of chiropractic approved by the Council on Chiropractic Education.
2. Whether the procedure is based upon anatomical, physiological and/or structural relationships which can be verified through standard diagnostic procedures.;
3. Whether the procedure has been supported by a body of evidence using standard scientific research methodology and whether the procedure has had periodic review by the Board based on current research as evidenced by:
   a. Publication in a peer reviewed professional or scientific journal (e.g. Spine, Journal of Manipulative and Physiological Therapeutics (JMPT), Bone and Joint Surgery).
   b. Supportive preliminary results in a peer review journal.
   c. Investigation in progress, sponsored by an agency independent of the procedure's proponents and/or developers (e.g., Federation of Chiropractic Education and Research).
   d. Hypothesis clearly derived from supportive literature published in peer reviewed journals or texts.

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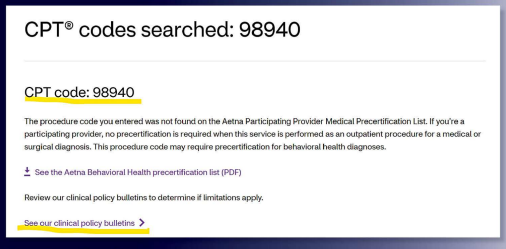
3rd Party Policy



CPT® codes searched: 98940

CPT code: 98940

The procedure code you entered was not found on the Aetna Participating Provider Medical Precertification List. If you're a participating provider, no precertification is required when this service is performed as an outpatient procedure for a medical or surgical diagnosis. This procedure code may require precertification for behavioral health diagnoses.

See the Aetna Behavioral Health precertification list (PDF)

Review our clinical policy bulletins to determine if limitations apply.

See our clinical policy bulletins

- Sometimes different coding and/or documentation is required than your practice's standard
- You need a written policy for how you will address the different standards

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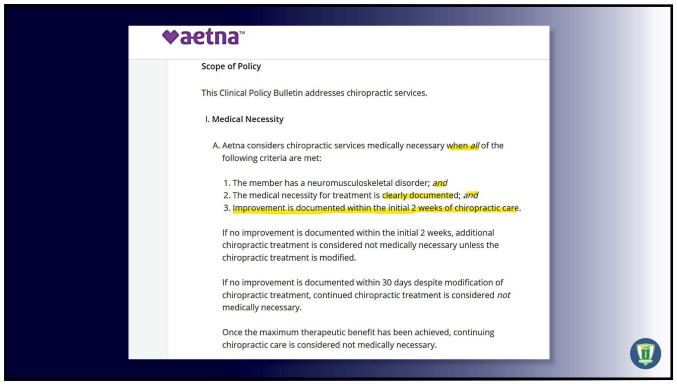

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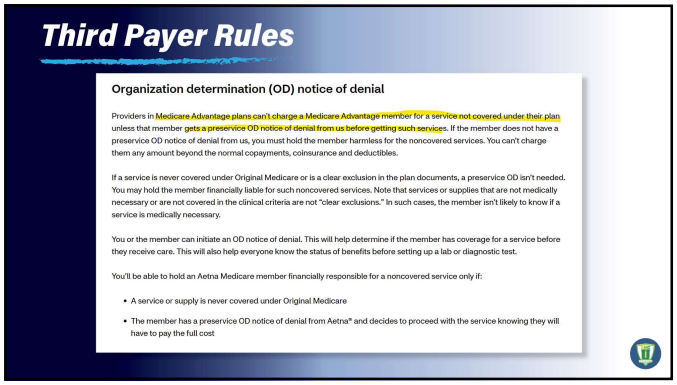

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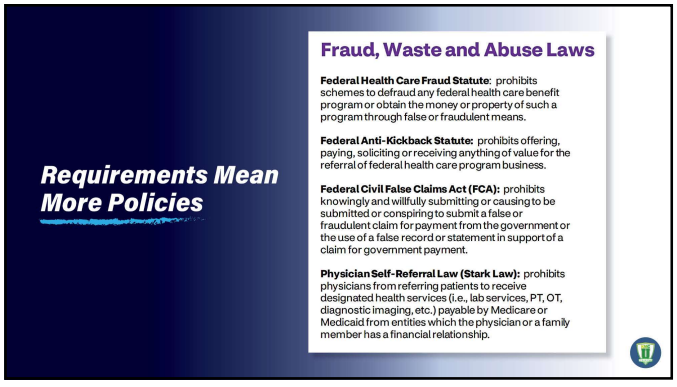

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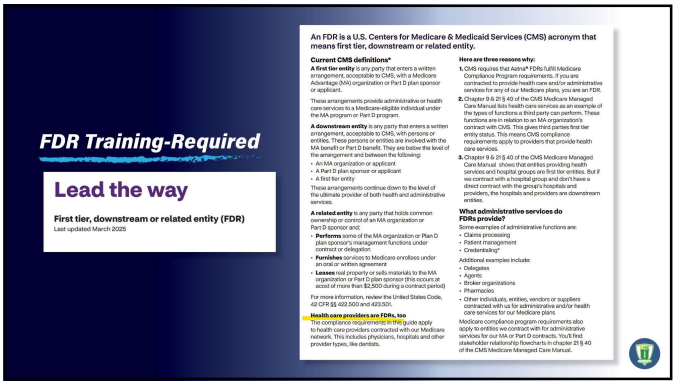

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The Code of Conduct

"A code of conduct is an important tool to communicate an organization's mission, goals, and ethical requirements central to its operations."
HHS Compliance Guidance

It means employees must report all compliance concerns to the internal Compliance Officer before reporting to an outside entity.

It is the first step to creating a compliant culture in the practice!

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Compliance Leadership and Oversight

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Daily, Weekly, Monthly, Annual and As Needed Duties

- ***Let's Review---***
- ***Daily:*** *Ongoing monitoring*
- ***Weekly:*** *Team meeting training; review recommended concerns*
- ***Monthly:*** *Compliance meeting with doctor; spot check 1-4 notes per provider; random EOB review*
- ***Annually:*** *Complete audit of 5-10 charts per provider; complete coding audit; review all provider contracts; review existing policy and procedure; annual compliance meeting with the team; renew the practice's Code of Conduct; confirm key team members have completed annual training; conduct formal compliance training with the entire team*

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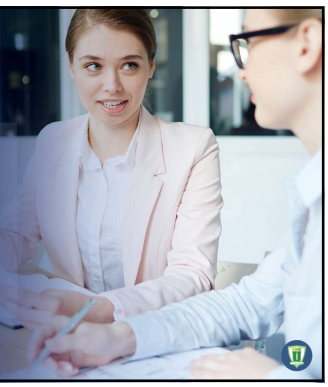
As Needed Duties



- *Initial compliance training for new team members, within 10 to 90 days of employment*
- *Ongoing, and remedial training based on audit findings or spot check findings*
- *Ongoing case work for compliance incidents*

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Maintain Your Program

- *1-3 hours per month*
- *Go-to resource*
- *Got a question? Is there a policy for that?*
- *Create more policy and procedure as you go*
- *Keep to a compliance calendar*

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Practice Name
COMPLIANCE OFFICER'S ANNUAL CALENDAR

JANUARY 2025

SUN	MON	TUE	WED	THU	FRI	SAT
			1	2 Annual Audit of 5-10 charts per provider	3	
	6 Review reported compliance concerns	7	8	9	10	
	13 Review reported compliance concerns	14	15	16 Random EOB Review	17	
	20 Review reported compliance concern	21	22	23 Randomly check four notes per provider	24	
	27 Review reported compliance concerns	28 Lay out annual training calendar for all key team members—CE + compliance	29 Monthly Compliance Meeting with Dr.	30	31	

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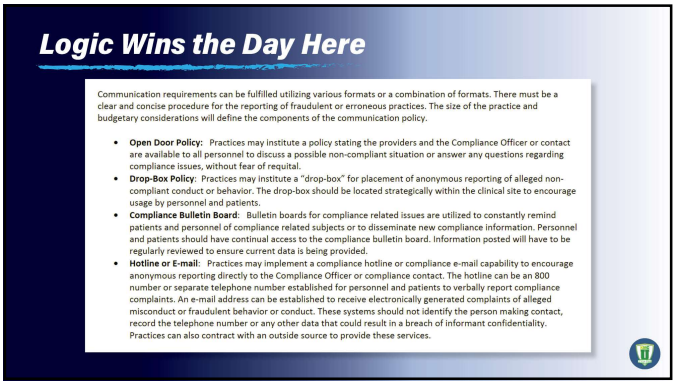

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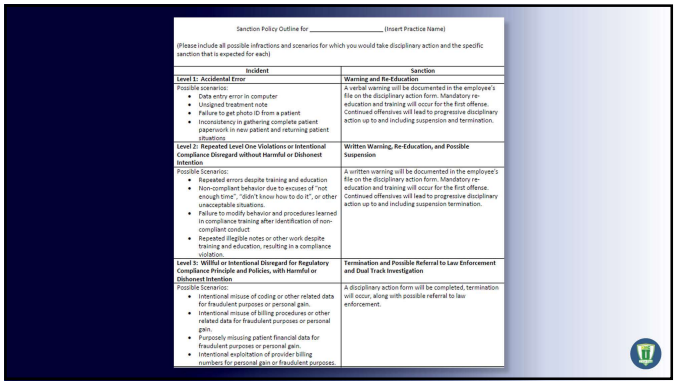

Sanction Policy Outline for _____ (Insert Practice Name)

(Please include all possible infractions and scenarios for which you would take disciplinary action and the specific sanction that is expected for each)

Incident	Sanction
Level 1: Accidental Error	**Warning and Re-Education**
Possible scenarios: • Data entry error in computer • Unsigned treatment note • Failure to get photo ID from a patient • Inconsistency in gathering complete patient paperwork in new patient and returning patient situations	A verbal warning will be documented in the employee's file on the disciplinary action form. Mandatory re-education and training will occur for the first offense. Continued offensives will lead to progressive disciplinary action up to and including suspension and termination.
Level 2: Repeated Level One Violations or Intentional Compliance Disregard without Harmful or Dishonest Intention	**Written Warning, Re-Education, and Possible Suspension**
Possible Scenarios: • Repeated errors despite training and education • Non-compliant behavior due to excuses of "not enough time", "didn't know how to do it", or other unacceptable situations. • Failure to modify behavior and procedures learned in compliance training after identification of non-compliant conduct • Repeated illegible notes or other work despite training and education, resulting in a compliance violation.	A written warning will be documented in the employee's file on the disciplinary action form. Mandatory re-education and training will occur for the first offense. Continued offensives will lead to progressive disciplinary action up to and including suspension termination.
Level 3: Willful or Intentional Disregard for Regulatory Compliance Principle and Policies, with Harmful or Dishonest Intention	**Termination and Possible Referral to Law Enforcement and Dual Track Investigation**
Possible Scenarios: • Intentional misuse of coding or other related data for fraudulent purposes or personal gain. • Intentional misuse of billing procedures or other related data for fraudulent purposes or personal gain. • Purposely misusing patient financial data for fraudulent purposes or personal gain. • Intentional exploitation of provider billing numbers for personal gain or fraudulent purposes.	A disciplinary action form will be completed, termination will occur, along with possible referral to law enforcement.

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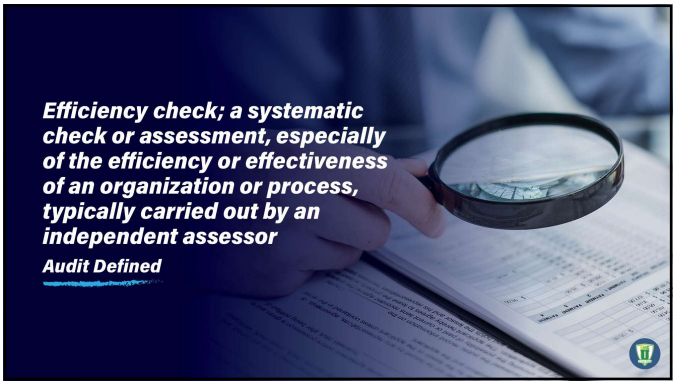

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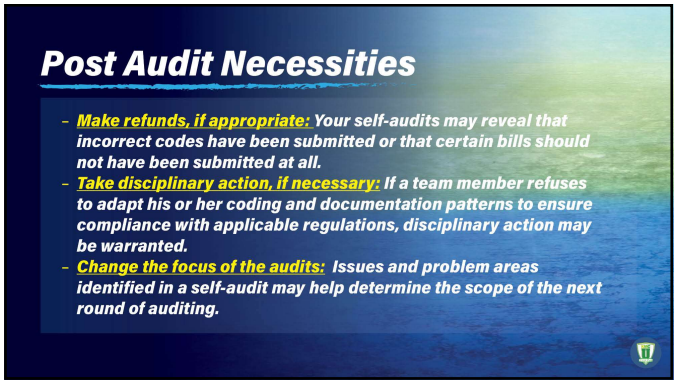

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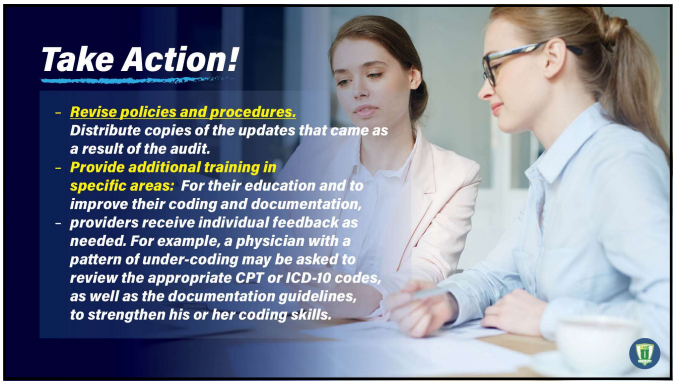

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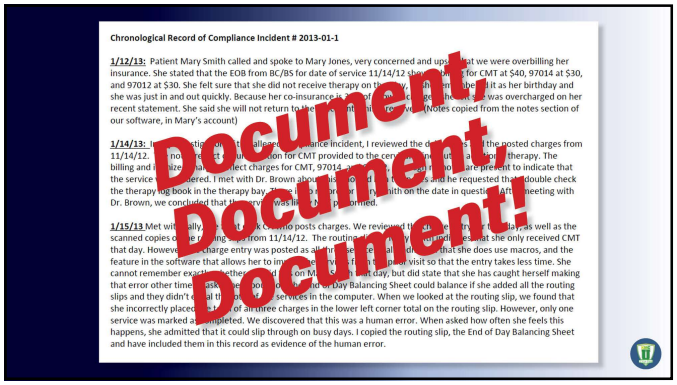

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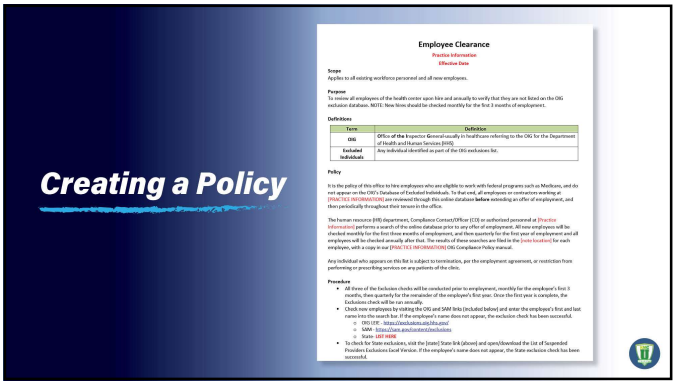

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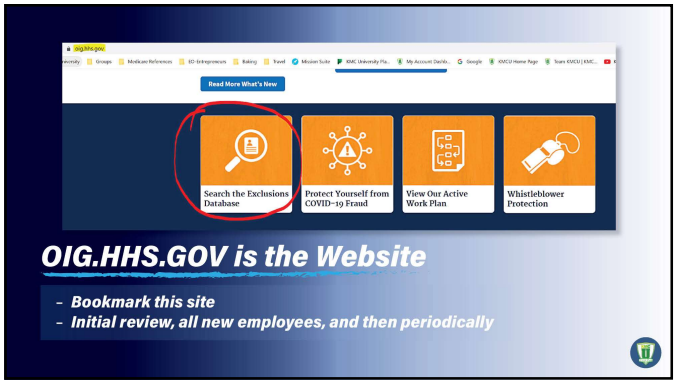

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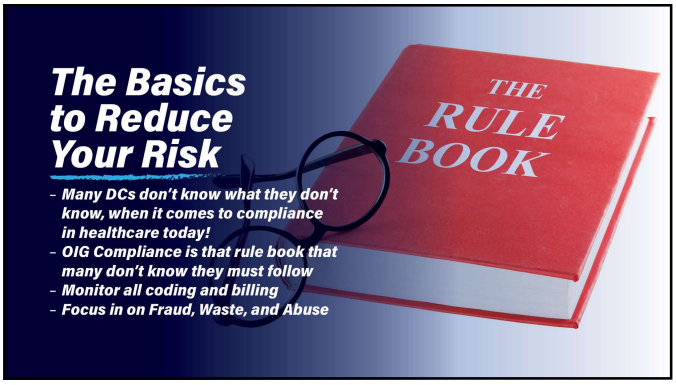

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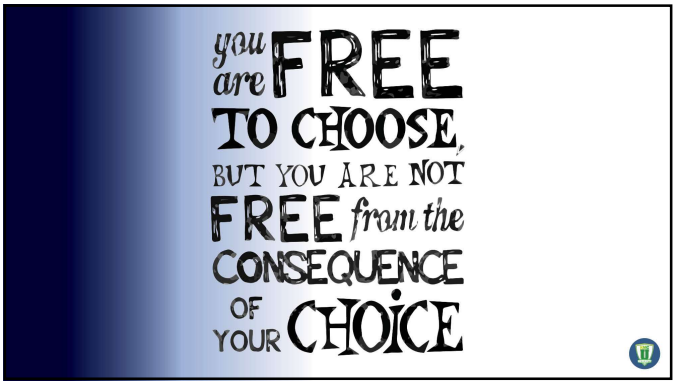

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