



OIG Compliance: Why Should I Care?

Presented by:
Kathy Weidner, MSCP, CPCO, CCP, CCCA
Dr. Colleen G. Auehnbach, DC, CPCO, CPMA

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Steps to Obtain CE Credits

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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Continuing Education Information

States Eligible for PACE Continuing Education Credits

The following states offer CE credits for at this event



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Today's Objectives


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

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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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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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OIG Audit Experience



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COMPLIANCE

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



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OIG Audit Experience

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



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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

- 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



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OIG Audit Experience

- A Medical Review Contractor was assigned to determine whether the services were allowable
- After many months, they executed a draft report of findings
- Exit conference call was held with all parties



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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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OIG Audit Experience

- Opportunity to submit written comments in response to the draft report
- Final report issued to the practice

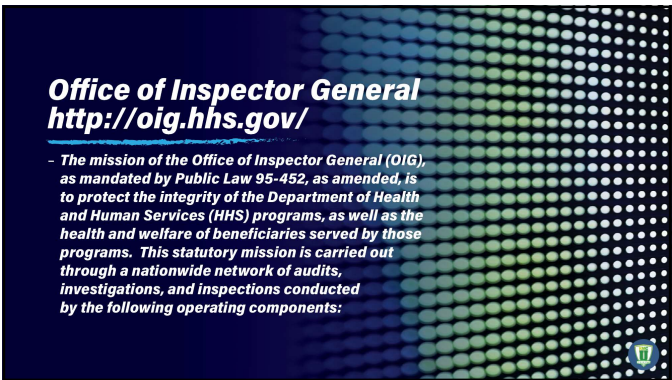


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Office of Inspector General

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

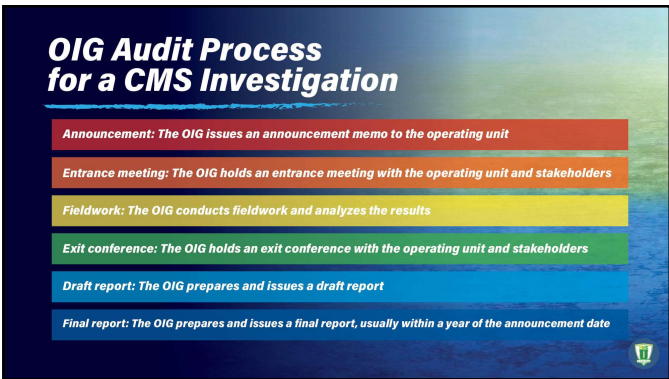
- The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried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



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OIG Audit Process for a CMS Investigation

- Announcement: The OIG issues an announcement memo to the operating unit
- Entrance meeting: The OIG holds an entrance meeting with the operating unit and stakeholders
- Fieldwork: The OIG conducts fieldwork and analyzes the results
- Exit conference: The OIG holds an exit conference with the operating unit and stakeholders
- Draft report: The OIG prepares and issues a draft report
- Final report: The OIG prepares and issues a final report, usually within a year of the announcement date



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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.

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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

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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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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."

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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

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

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Chiropractic Services

- Chiropractic services focus on the body's main structures—the skeleton, the muscles, and the nerves. Chiropractors make adjustments to these structures, particularly the spinal column. They do not prescribe drugs or perform surgical procedures, although they refer patients for these services if they are medically indicated. Most patients seek chiropractic care for back pain, neck pain, and joint problems.



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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 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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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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What Next?

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

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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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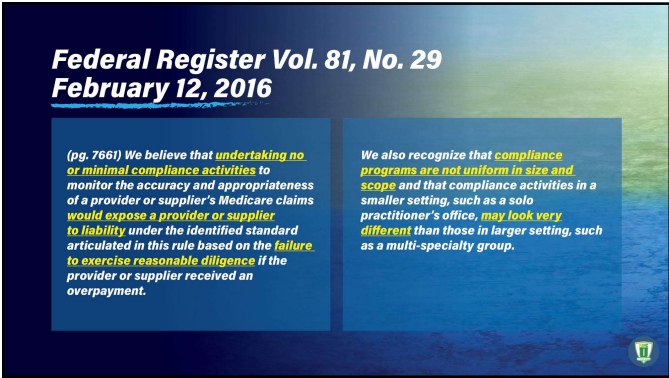
MANAGEMENT STYLES

Checks and Balances

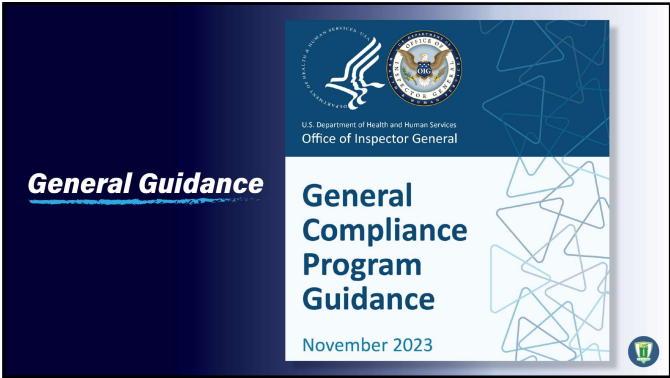
REACTIVE
Reacting to a problem after it arises.

PROACTIVE
Preventing problems before they arise.

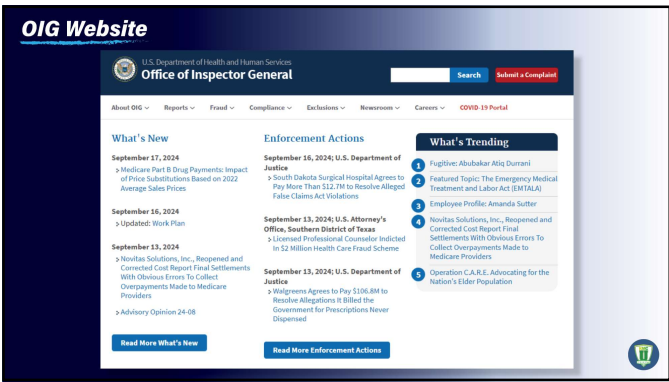
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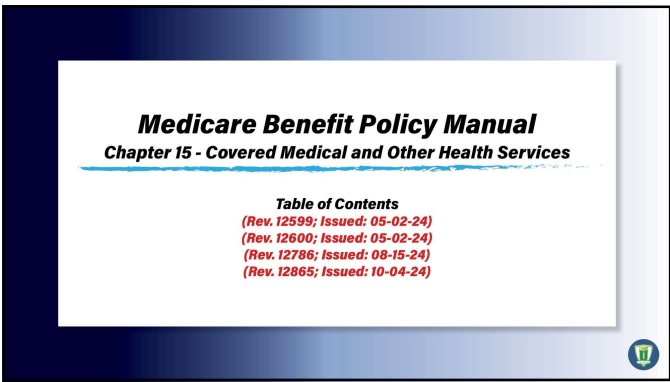
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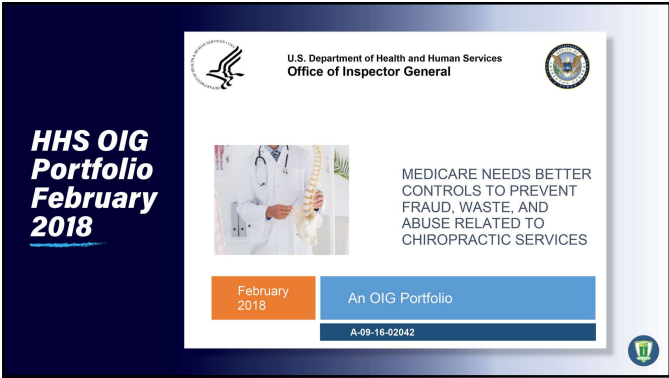
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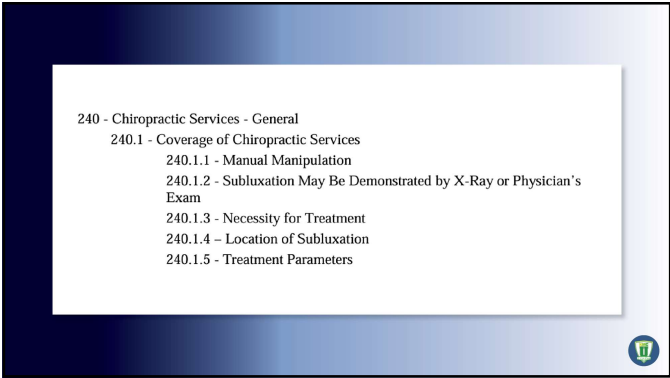
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240 - Chiropractic Services - General
(Rev. 1, 10-01-03)
B3-2250, B3-4118

The term "physician" under Part B includes a chiropractor who meets the specified qualifying requirements set forth in §30.5 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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☐ Part A news
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☐ Part A and B Electronic data interchange (EDI)

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FIRST COAST SERVICE OPTIONS, INC.

Enter search keywords Entire site (Excluding archives)

SPOT feature highlight:
Provider Data Summary

Follow us | Testimonials | SPOT features

Quick clicks

- Coronavirus / telehealth
- Processing issues
- Fee schedules
- Annual deductibles/coinsurance
- Modifiers
- Enroll as a provider
- Update provider information
- Claims processing codes
- Missed RT? View a recap

SPOT Claims status, Eligibility & benefits, Recent payment information, Comparative data analysis

New account?

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What An OIG Compliance Program Is

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Billing and Coding: Chiropractic Services

ASB412 Export All | Collapse All

NOT AN LCD REFERENCE ARTICLE
This article is not in direct support of an LCD. [Learn more](#)

Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	States
First Coast Service Options, Inc.	A and B MAC	09101 - MAC A	J - N	Florida
First Coast Service Options, Inc.	A and B MAC	09102 - MAC B	J - N	Florida
First Coast Service Options, Inc.	A and B MAC	09201 - MAC A	J - N	Puerto Rico Virgin Islands
First Coast Service Options, Inc.	A and B MAC	09202 - MAC B	J - N	Puerto Rico
First Coast Service Options, Inc.	A and B MAC	09302 - MAC B	J - N	Virgin Islands

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Compliance Program Purpose

- Integrate policies and procedures into the physician's practice that are necessary to promote adherence to federal and state laws and statutes and regulations applicable to the delivery of healthcare services

Purpose

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Parts of an Effective Office Compliance Program

- **OIG compliance**
- **HIPAA**
- **OSHA**
- **CLIA**
- **Anti-Kickback Laws**
- **Stark Laws**
- **State laws**
- **Employment Laws**

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What An **OIG Compliance Program** Isn't

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Elements of an **OIG Compliance Program**

Establish and implement policies and procedures

Assign a compliance official or contact

Employ comprehensive education and training

Enforce disciplinary standards

Research and document all staff and providers

Maintain open lines of communication

Perform internal auditing and monitoring

Respond swiftly to detected offenses

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A "Program" is Not a "Manual"

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The Small Provider Version- **Six Elements**

- **Compliance Contact** - The GCPG takes into consideration that most small entities cannot employ a full-time or part-time compliance officer. The recommendation is to have a point of contact for compliance related activities.
- **Policies, Procedures and Training** - a clinic needs to develop written policies, customized procedures on how to perform duties in line with healthcare compliance along with documented training. *(this is where I became 6)*
- **Open Lines of Communication** - a clinic should ensure all workforce members are aware of the practice's compliance stance, potential issues, and method of reporting concerns (anonymously when possible).
- **Risk Assessment, Auditing & Monitoring** - a clinic must identify potential risk through auditing and risk assessment. Once risks are identified, the compliance officer must monitor for new or unidentified risks, updates, and revised standards. Clinics should conduct at least one annual risk assessment/audit.
- **Enforcing Standards** - a clinic must establish disciplinary action and enforcement activities and permit workforce members to ask questions and report mistakes. Enforcement can include incentives for compliance performance.
- **Responding to Detected Offenses & Developing Corrective Action Initiatives** - audits may reveal potential legal violations which require written corrective actions. These should include detailed corrective steps, an assigned workforce member, target dates for completion and any reporting to law enforcement agency if necessary.

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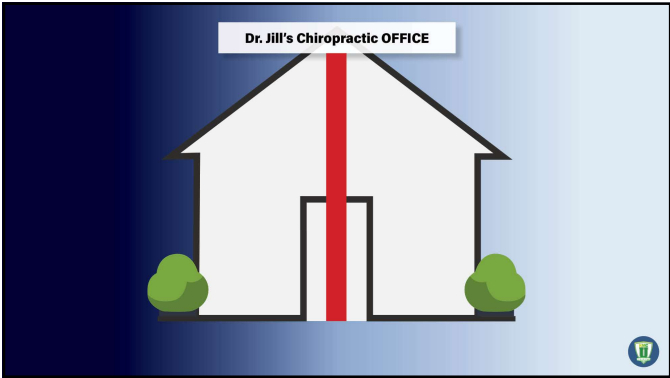
Known Violations: **Per** **OIG**

- 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)

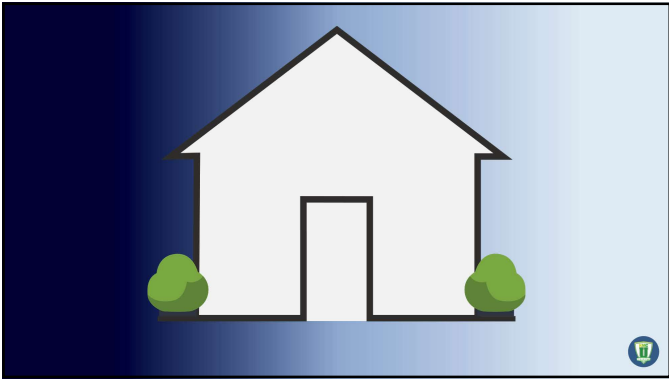
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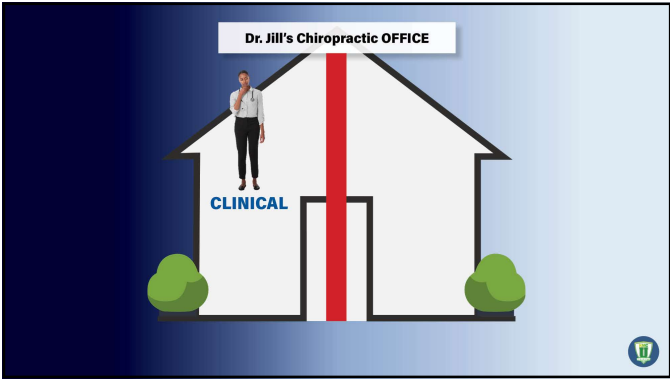
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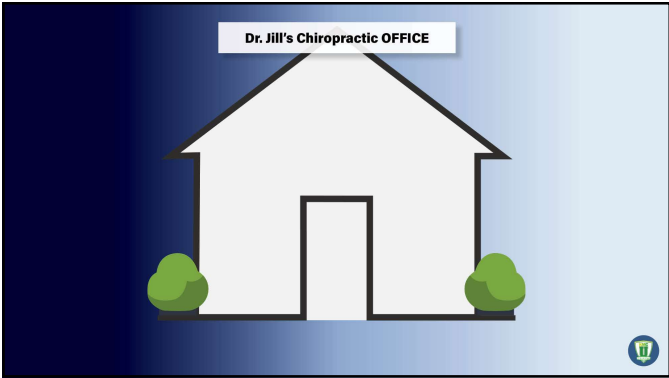
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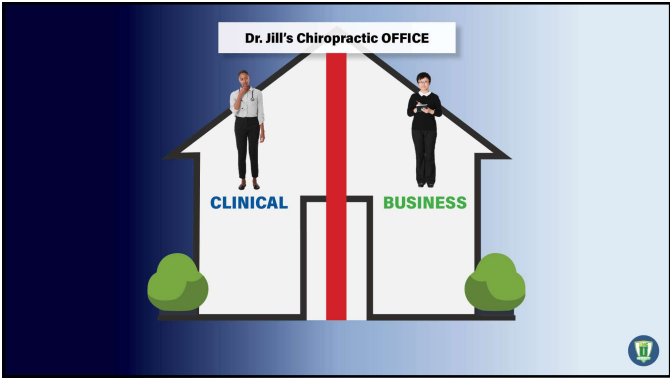
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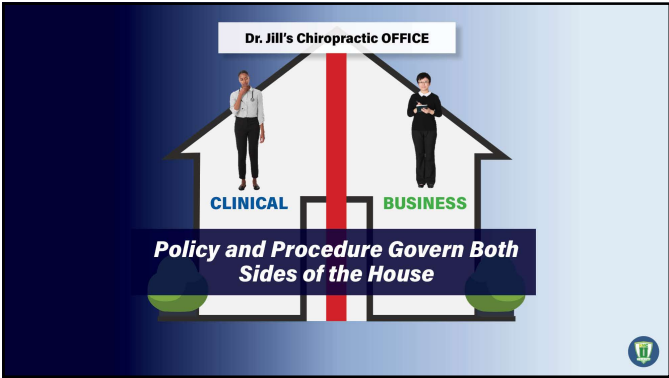
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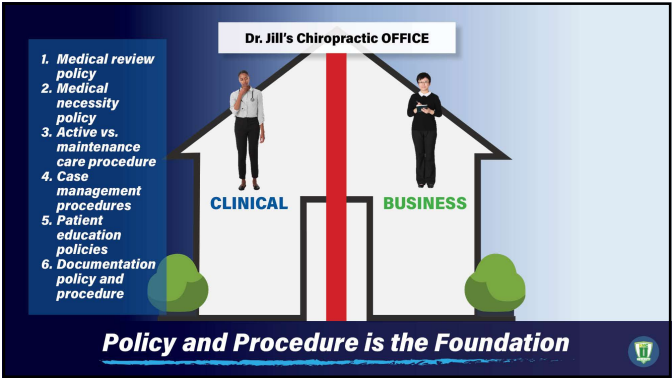
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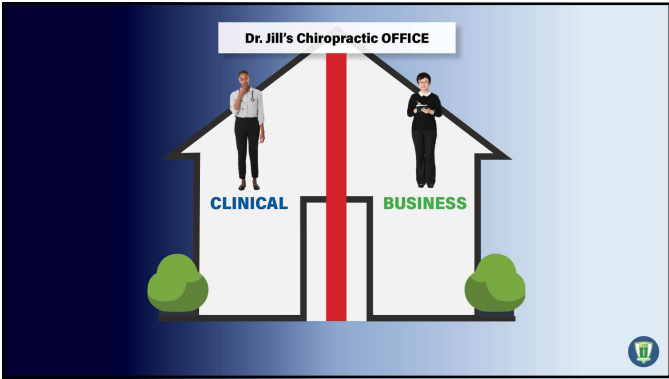
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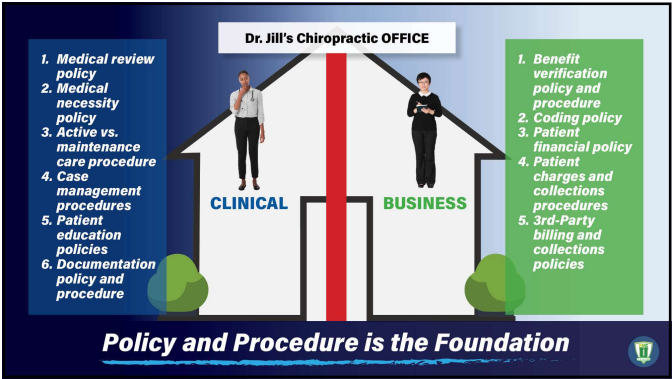
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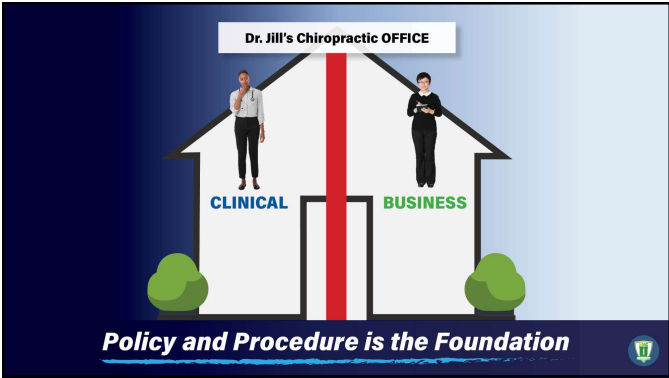
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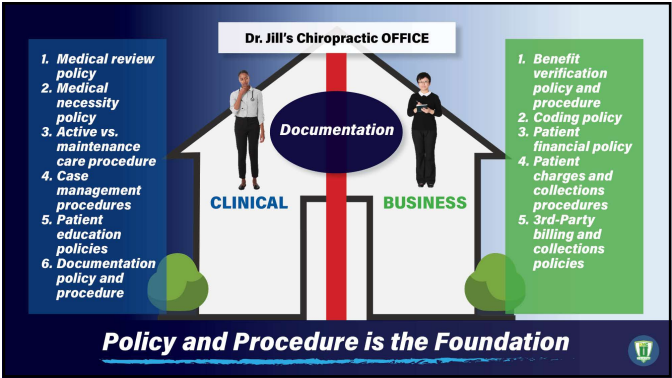
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OIG Recommends Policies and Procedures to Address THESE Risks

The slide features four circular icons arranged in a 2x2 grid. Each icon has a red border and a white center. The top-left icon is labeled 'MEDICAL NECESSITY' and shows a document with a checkmark. The top-right icon is labeled 'BILLING AND CODING ERRORS' and shows a document with a red 'X' and the numbers 97030, 98942, 97112, G0283, and 97012. The bottom-left icon is labeled 'PATIENT FINANCIAL INCONSISTENCIES' and shows two gold coins with dollar signs. The bottom-right icon is labeled 'POOR DOCUMENTATION' and shows a yellow folder with a document. A small KMC logo is in the bottom right corner.

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What the Office Must Know

The slide shows a flowchart with four colored boxes connected by arrows. The first box is red and asks 'Is the patient eligible for services today?'. The second box is orange and asks 'Have I verified the specific benefits for the services I intend to render?'. The third box is green and asks 'Did I compare the services I intend to render to the payer's medical review policy to check for services that may be deemed experimental, unproven, or investigational? And am I clear about the payer's definition of medical necessity?'. The fourth box is blue and asks 'Did I review the coding and documentation requirements in the payer's medical review policy to ensure we know the rules of engagement and can produce a valid, reimbursable claim?'. A small KMC logo is in the bottom right corner.

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Most Significant Compliance Risks We See

The slide features a man in a dark suit and white shirt walking a tightrope. He is holding a briefcase in his right hand and has his left arm outstretched for balance. The background is a gradient of blue and green. The text on the left lists several compliance risks. A small KMC logo is in the bottom right corner.

- Lack of understanding of the Big Four Steps to compliance as we see it
- Lack of differentiating medical necessity from clinical appropriateness.
- Disconnecting from the rules of billing because "I'm the Provider of Service" not the biller
- The attitude that the rules don't apply to me because I run a cash practice
- And, by the way, I don't keep up with the rules because I'm too busy... but I try to belong to lots of random free Facebook groups to get my advice

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What the Office Must Know

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What We Call "The Big Four"

The slide features a Venn diagram with two overlapping circles. The left circle is green and labeled 'WANT'. The right circle is blue and labeled 'NEED'. In the center, where the circles overlap, is a red star with the words 'MUST HAVE' in white. The background is a gradient of blue and green. A small KMC logo is in the bottom right corner.

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1. Is the Patient Eligible for Services Today?

- Online portals are useful here
- Compliance Risk = using effective date on the card
- Compliance Risk = not checking eligibility at all

Save time and money with our market leading solution!

Streamlining your eligibility and benefits, claims management, and authorizations

Collaborating for patient care requires constant connectivity and up-to-date information. Simplifying how you exchange that information with your payers is more important than ever. Availity makes it easy to work with payers, from the first check of a patient's eligibility through final resolution of your reimbursement.

Availity is the destination where providers connect with their payers to get the answers they need to focus

Availity

Availity is where healthcare connects. Payer-provider collaboration starts here!

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Why Verify Medicare?

- Is it so easy that it doesn't require verification?
- Everyone has the same coverage, right?

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Eligibility is NOT the Same as Verification

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Verify ALL Coverage

- Confirm Medicare Part B eligibility
- Confirm secondary or supplemental eligibility
- Confirm actual chiropractic benefits for any secondary or supplemental
- If Medicare Part C, confirm all benefits

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2. Have I verified the specific benefits for the services I intend to render?

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Know Who Pays First

ID	Title	Type	Description
01	Curriculum	PDF	A printable listing of the courses and their descriptions for the MSP CBT Curriculum.
02	Introduction to Medicare	PDF	The Introduction to Medicare course provides background and history on Medicare, a comparison of Medicare and Medicaid, an explanation of entitlement including age, disability and End Stage Renal Disease (ESRD), and concludes with the parts of Medicare.
03	MSP Overview	PDF	The MSP Overview course begins with a definition of Medicare Secondary Payer. This course also explores the relationship of the provisions of Medicare Secondary Payer with State law. Next, it provides information on the two broad categories of MSP: Group Health Plan (GHP) and Non-group Health Plan (NGHP), and for a final topic, addresses Coordination of Benefits.
04	MSP Working Agent	PDF	This course provides an overview of the MSP provisions of the Social Security Act for beneficiaries entitled to Medicare based on age, provides guidelines for the small employer exception, provides examples showing when Medicare would be the secondary payer, and provide employer and Group Health Plan (GHP) guidelines for Working Agent MSP.
05	Medicare Secondary Payer Disability	PDF	This course provides an overview on the MSP provisions of the Social Security Act for beneficiaries entitled to Medicare based on a disability, provides guidelines in regards to employer size considerations, provides examples showing when Medicare would be the secondary payer, and provides employer and Group Health Plan (GHP) guidelines.
06	MSP End Stage Renal Disease (ESRD)	PDF	This course provides an in-depth discussion of the MSP Guidelines for persons entitled to Medicare because of End Stage Renal Disease (ESRD). Multiple examples of ESRD MSP situations are provided. The course then addresses MSP as it relates to those individuals that have dual entitlement to Medicare, i.e., entitled to Medicare for more than one reason, e.g., ESRD and Working Agent, or ESRD and Disability Agent, multiple examples are provided to assure clarity of the guidelines.

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3. Locate and Review Payer's Medical Review Policy

Did I compare the services I intend to render to the payer's medical review policy to check for services that may be deemed experimental, unproven, or investigational? And am I clear about the payer's definition of medical necessity?

Cigna Chiropractic MRP

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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

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4. Understand and Implement Coding and Documentation Policy


Did I review the coding and documentation requirements in the payer's medical review policy to ensure we know the rules of engagement and can produce a valid, reimbursable claim?

Cigna Chiropractic MRP

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#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."

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Risk #1



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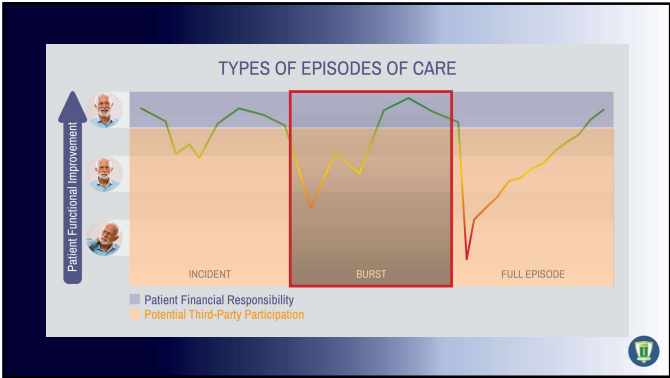
Both Doctor and Patient Must Know When It's Active and When It's Maintenance



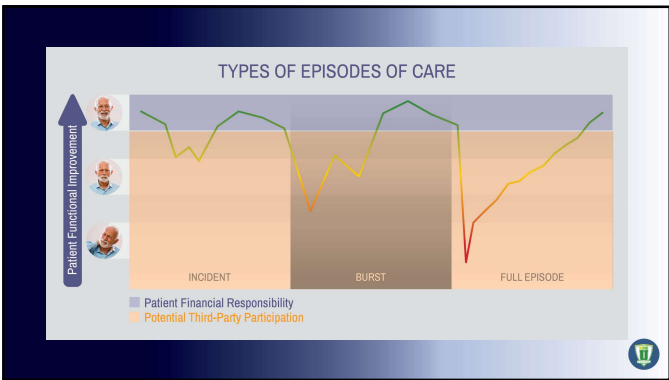
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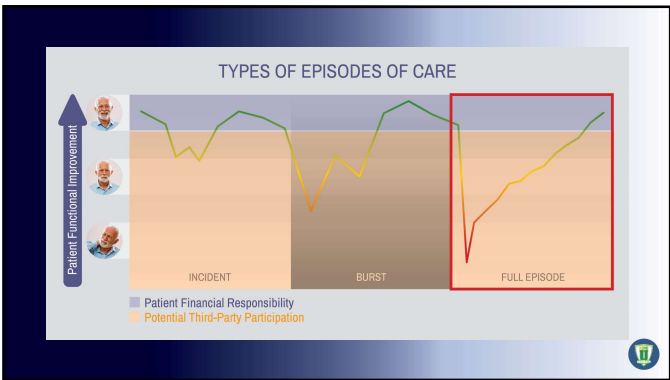
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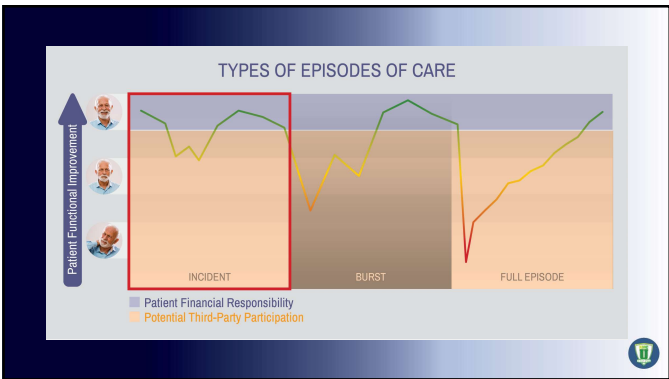
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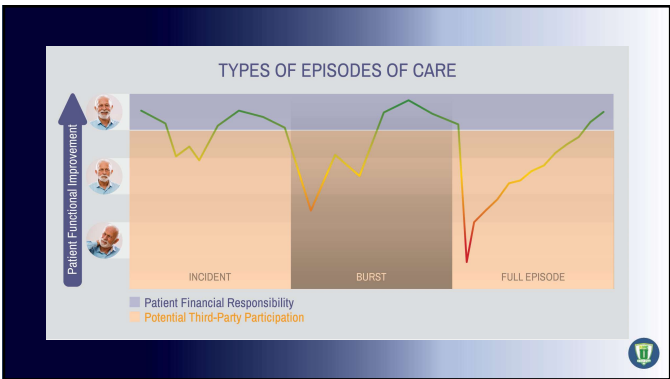
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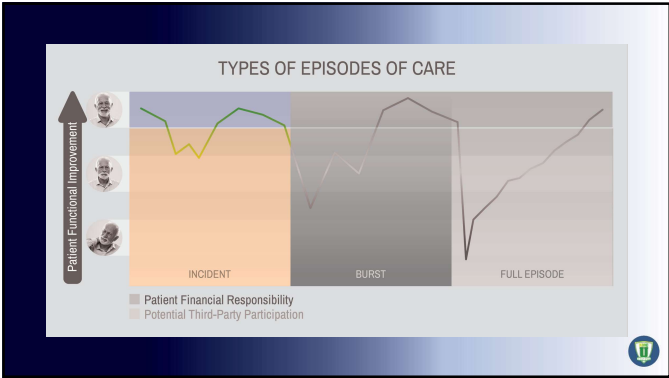
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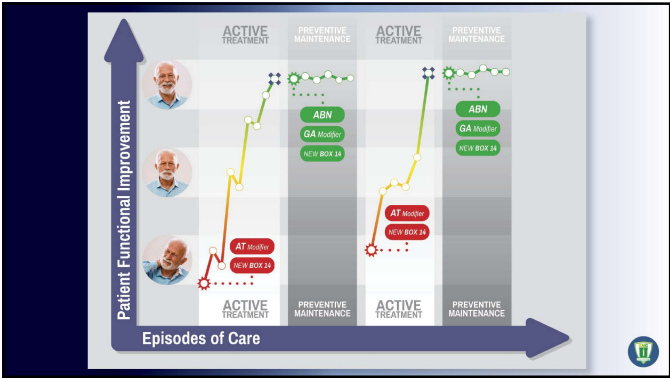
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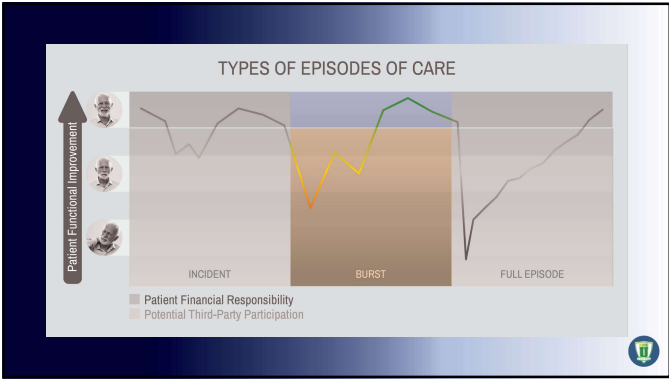
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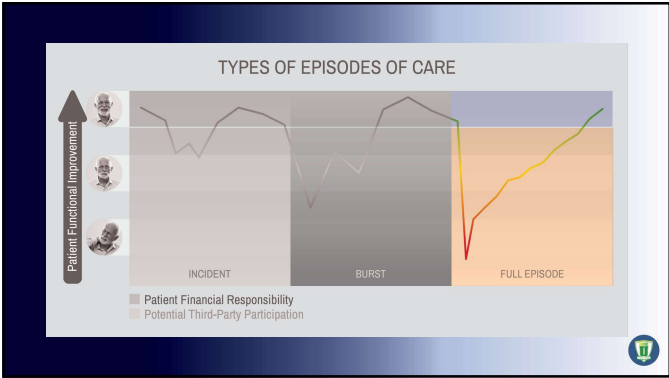
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Understand and Implement Medical Necessity Definitions

The definition of Medical Necessity, per Medicare, is:

- The patient must have a **significant health problem** in the form of a **neuromusculoskeletal condition** necessitating treatment, and the manipulative services rendered must have a **direct therapeutic relationship** to the patient's condition and **provide reasonable expectation of recovery or improvement of function**.

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87

AT = Active Treatment

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

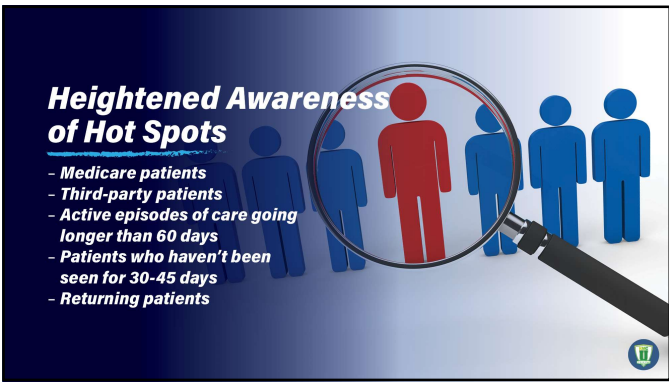
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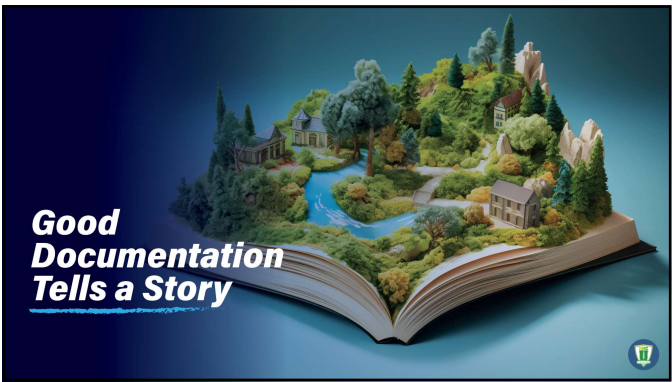
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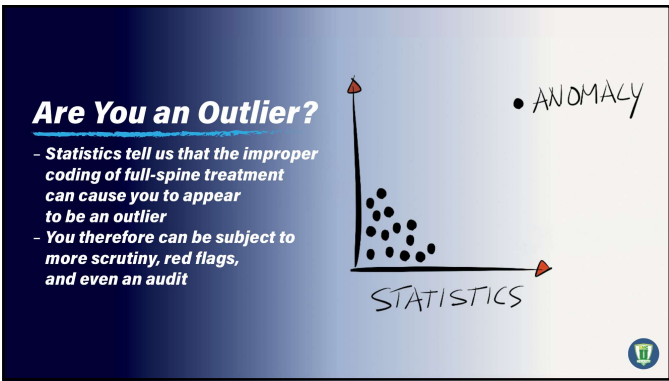
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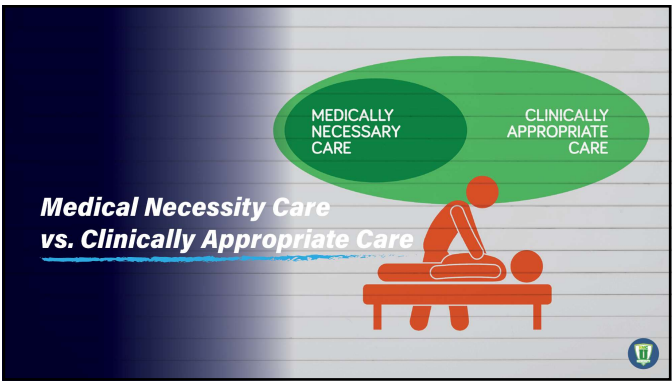
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The Life Cycle of the Patient's Record

- 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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EITHER

E/M vs. SOAP


OR



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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



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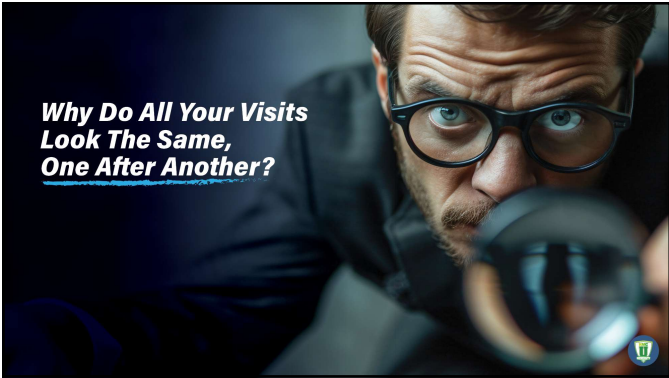
What Medicare and Other Payers Want to See

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

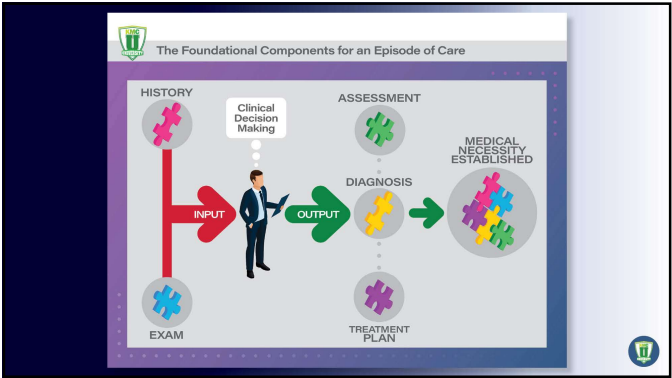


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Episodes of Care



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Medicare Documentation Guidelines in the Absence of Others

Initial Visit	Subsequent Visits
- History	- History
- Description of Present Illness	- Review of chief complaint
- Physical Exam	- Physical Exam
- Diagnosis	- Document daily treatment
- Treatment Plan	- Progress related to treatment goals/plan
- Date of Initial treatment	

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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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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/Perception 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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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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An Incident-Within SOAP Documentation

Assessment:
Fred has suffered a recurrence 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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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 subacute event, capable of causing a significant neuromusculoskeletal (NMS) condition, and does the patient have a documented loss of function that can be improved?

YES → CONSIDER: Will the condition likely be resolved within 1-3 visits? → YES → DOCUMENT: Incident

NO → CONSIDER: Will the condition likely be resolved within about a month? → YES → DOCUMENT: Burst

NO → CONSIDER: Will the condition likely require treatment beyond a month? → YES → DOCUMENT: Episode

Incident

- History/Chief Complaint
- Mechanism of Injury
- DATs result and score
- Exam/Physical Indings/PART
- DX: Seg. Dys. + Primary condition per region treated
- Measurable functional deficits
- TX Plan including goals and discharge
- Formal EM service may not be necessary. Documentation within CMT may be possible.

Burst

- History/Chief Complaint
- Mechanism of Injury
- DATs result and score
- Exam/Physical Indings/PART
- DX: Seg. Dys. + Primary condition per region treated
- Measurable functional deficits
- TX Plan including goals and discharge
- Formal EM service necessary to establish medical necessity for this much care.

Episode

- History/Chief Complaint
- Mechanism of Injury
- DATs result and score
- Exam/Physical Indings/PART
- DX: Seg. Dys. + Primary condition per region treated
- Measurable functional deficits
- TX Plan including goals
- Formal EM service necessary to establish medical necessity for this much care.

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Risk #3

BILLING AND CODING ERRORS

97530 98942 G0283 97112 97012

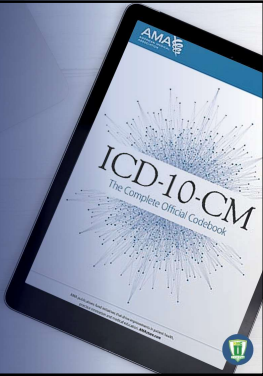
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Billing

- 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



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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



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CMT Coding and Regions

Spinal:

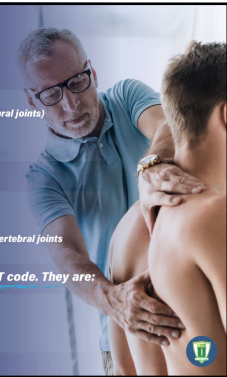
Cervical: The atlanto-occipital joint (C0/C1), and C1 through C7
Thoracic: T1 through T12, including the posterior ribs (costotransverse and costovertebral joints)
Lumbar: L1 through L5
Sacral: The sacrum, including the sacrococcygeal joint
Pelvic: The sacroiliac joints and other pelvic articulations

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
98942: CMT, 3 or 4 spinal regions as noted above
98943: CMT, 5 spinal regions as noted above
98944: 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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Coding Oddities

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





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Group 1 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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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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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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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



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Fee System Essentials



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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

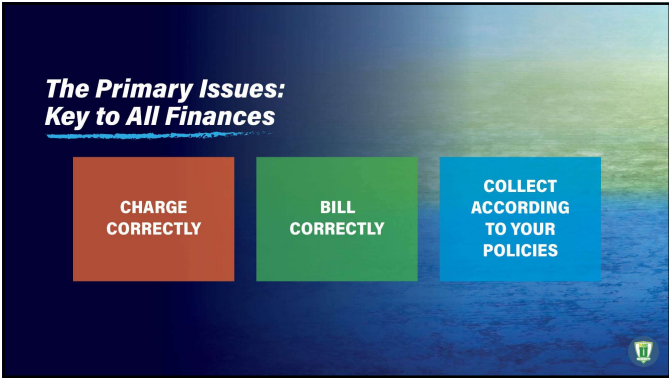


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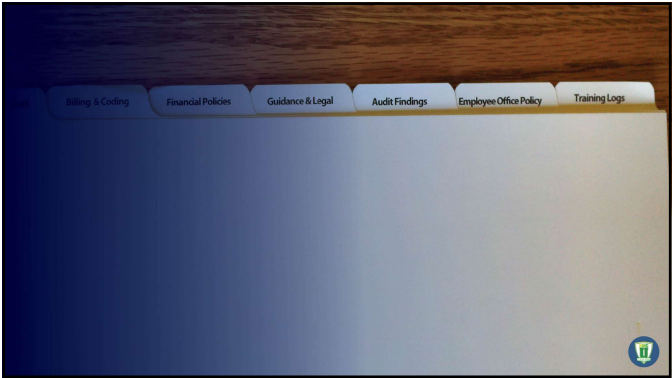
Know Your Discounts & Know What Is and Isn't Legal



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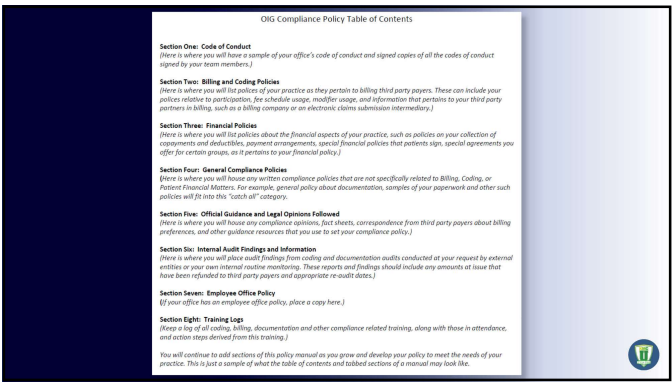
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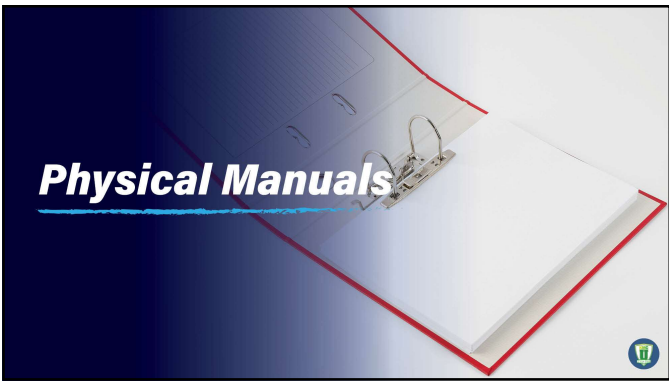
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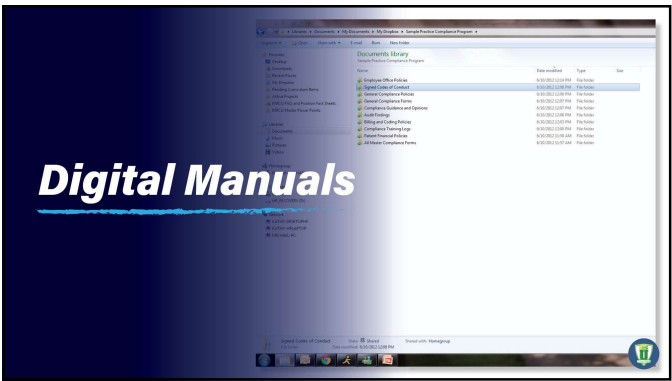
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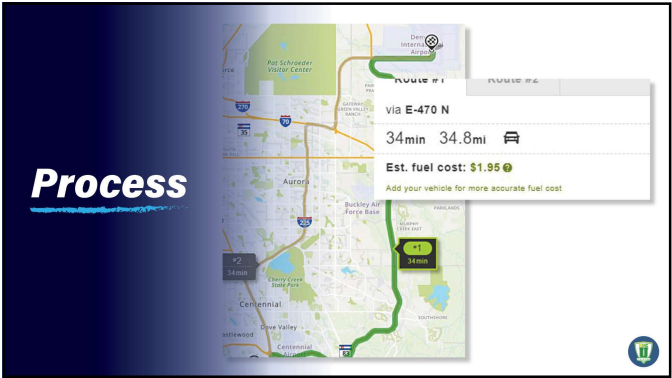
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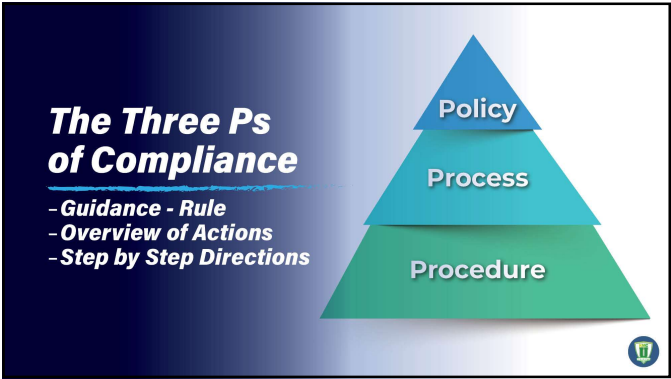
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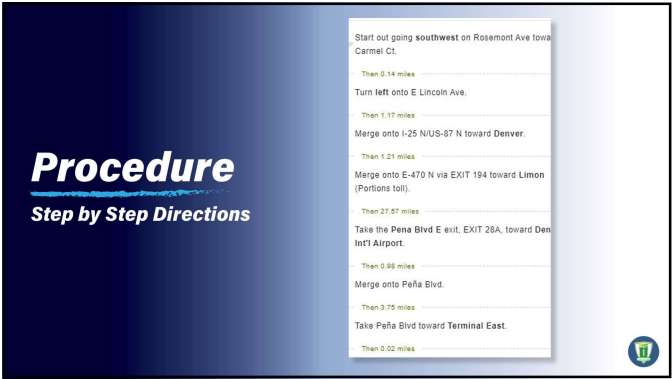
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What is the Difference?

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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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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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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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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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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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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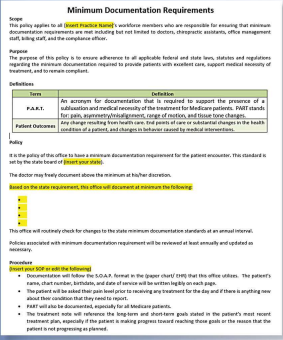
Policies for Each Organization

- **OIG (Office of Inspector General)** requires policies for healthcare operations
- **OCR (Office of Civil Rights)** requires policies 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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Sample Policy Example of What May be Required



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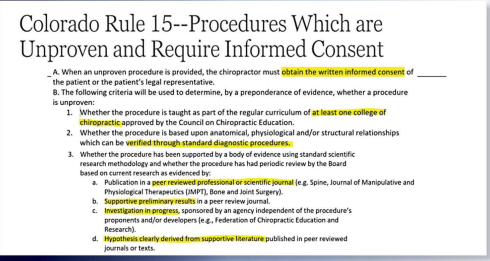
Conflicting Guidelines

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!



158

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



161

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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3rd Party Policy

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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Scope of Policy

This Clinical Policy Bulletin addresses chiropractic services.

I. Medical Necessity

A. Aetna considers chiropractic services medically necessary **when all** of the following criteria are met:

1. The member has a neuromusculoskeletal disorder; **and**
2. The medical necessity for treatment is **clearly documented; and**
3. **Improvement is documented within the initial 2 weeks of chiropractic care.**

If no improvement is documented within the initial 2 weeks, additional chiropractic treatment is considered not medically necessary unless the chiropractic treatment is modified.

If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is considered not medically necessary.

Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is considered not medically necessary.

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Payer Requirements for Medicare Compliance

Complete your required Medicare compliance training by December 31, 2023

Participating providers in our Medicare networks are required to meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related (FDR) entities as outlined in the FDR program guide.

- DSNP and/or FIDE providers must complete the annual Model of Care (MOC) training and attestation (when released in the summer) by December 31, 2023.
- Delegated providers/entities are required to attest based on contracted networks.

Aetna Medicare Advantage (MA) plans include HMOs, PPOs and DSNPs

To learn more about our MA plans, including DSNP plans, view our [Medicare Advantage Quick Reference Guide \(PDF\)](#).

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Third Payer Rules

Organization determination (OD) notice of denial

Providers in **Medicare Advantage plans can't charge a Medicare Advantage member for a service not covered under their plan** unless that member **gives a preservice OD notice of denial before getting such services**. If the member does not have a preservice OD notice of denial from us, you must hold the member harmless for the noncovered services. You can't charge them any amount beyond the normal copayments, coinsurance and deductibles.

If a service is never covered under Original Medicare or is a clear exclusion in the plan documents, a preservice OD isn't needed. You may hold the member financially liable for such noncovered services. Note that services or supplies that are not medically necessary or are not covered in the clinical criteria are not "clear exclusions." In such cases, the member isn't likely to know if a service is medically necessary.

You or the member can initiate an OD notice of denial. This will help determine if the member has coverage for a service before they receive care. This will also help everyone know the status of benefits before setting up a lab or diagnostic test.

You'll be able to hold an Aetna Medicare member financially responsible for a noncovered service only if:

- A service or supply is never covered under Original Medicare
- The member has a preservice OD notice of denial from Aetna® and decides to proceed with the service knowing they will have to pay the full cost

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FDR Training-Required

Lead the way

First tier, downstream or related entity (FDR)
Last updated March 2025

An FDR is a U.S. Centers for Medicare & Medicaid Services (CMS) acronym that means **first tier, downstream or related entity**.

Current CMS definitions*

A first tier entity is any party that enters a written arrangement, accessible to CMS, with a Medicare Advantage (MA) organization or Part D plan sponsor or agent.

These arrangements provide administrative or health care services to a Medicare eligible individual under the MA program or Part D program.

A downstream entity is any party that enters a written arrangement, accessible to CMS, with persons or entities. These persons or entities are included with the MA benefit or Part D benefit. They are below the level of the arrangement and between the following:

- An MA organization or agent
- A Part D plan sponsor or agent
- A first tier entity

These arrangements continue down to the level of the ultimate provider of both health and administrative services.

A related entity is any party that holds common ownership or control of an MA organization or Part D sponsor and:

- Performs services for the MA organization or Part D plan sponsor's management functions under contract or delegation
- Provides services to Medicare enrollees under contract or written agreement

Liabilities and property or value payable to the MA organization or Part D plan sponsor (this occurs at least of more than \$5,000 during a contract period).

For more information, review the United States Code, 42 CFR 422.502.503 and 42 CFR 422.504.

Health care providers are FDRs, too

The compliance requirements in this guide apply to health care providers contracted with our Medicare networks. This includes physicians, hospitals and other provider types, see details.

Here are three reasons why:

1. CMS requires that Aetna® FDRs fully Medicare Compliance Program requirements. If you're not, you're not in our Medicare plans, you're not in FDR.
2. Chapter 8 of 42 CFR of the CMS Medicare Managed Care Manual lists health care services as an example of the types of services a third party can perform. These functions are in relation to an MA organization's contract with CMS. This gives that party first tier entity status. This means CMS compliance requirements apply to providers that provide health care services.
3. Chapter 8 of 42 CFR of the CMS Medicare Managed Care Manual shows that entities providing health care services and hospitals are not first tier entities. But if we contract with a third party group and don't have a direct contract with the group's hospitals and providers, the hospitals and providers are downstream entities.

What administrative services do FDRs provide?

Some examples of administrative functions are:

- Claims processing
- Patient management
- Credentialing

Additional examples include:

- Call centers
- Agents
- Broker organizations
- Pharmacy
- Other individuals, entities, vendors or suppliers contracted with us for administrative and/or health care services for our Medicare plans.

Medicare compliance program requirements also apply to entities we contract with for administrative services for our MA or Part D contracts. You'll find additional relationship flowcharts in chapter 22 of 42 of the CMS Medicare Managed Care Manual.

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Requirements Mean More Policies

Fraud, Waste and Abuse Laws

Federal Health Care Fraud Statute: prohibits schemes to defraud any federal health care benefit program or obtain the money or property of such a program through false or fraudulent means.

Federal Anti-Kickback Statute: prohibits offering, paying, soliciting or receiving anything of value for the referral of federal health care program business.

Federal Civil False Claims Act (FCA): prohibits knowingly and willfully submitting or causing to be submitted or conspiring to submit a false or fraudulent claim for payment from the government or the use of a false record or statement in support of a claim for government payment.

Physician Self-Referral Law (Stark Law): prohibits physicians from referring patients to receive designated health services (i.e., lab services, PT, OT, diagnostic imaging, etc.) payable by Medicare or Medicaid from entities which the physician or a family member has a financial relationship.

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Ethics

Honesty

Integrity

Respect

Practice Code of Conduct

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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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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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Compliance Leadership and Oversight

QUEEN of COMPLIANCE

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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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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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Practice Name: _____

COMPLIANCE OFFICER'S ANNUAL CALENDAR

JANUARY 2025

SUN	MON	TUE	WED	THU	FRI	SAT
				1	2	3
		6	7	8	9	10
		13	14	15	16	17
		20	21	22	23	24
		27	28	29	30	31

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Take Time To Properly Train All Team Members

- Team members must be trained on Policy and Procedure
- Don't throw someone into their job
- Billing/coding/collections team members are a must
- Train at the beginning of employment and at least on an annual basis




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Logic Wins the Day Here

Communication requirements can be fulfilled utilizing various formats or a combination of formats. There must be a clear and concise procedure for the reporting of fraudulent or erroneous practices. The size of the practice and budgetary considerations will define the components of the communication policy.

- **Open Door Policy:** Practices may institute a policy stating the providers and the Compliance Officer or contact are available to all personnel to discuss a possible non-compliant situation or answer any questions regarding compliance issues, without fear of reprimand.
- **Drop-Box Policy:** Practices may institute a "drop-box" for placement of anonymous reporting of alleged non-compliant conduct or behavior. The drop-box should be located strategically within the clinical site to encourage usage by personnel and patients.
- **Compliance Bulletin Board:** Bulletin boards for compliance related issues are utilized to constantly remind patients and personnel of compliance related subjects or to disseminate new compliance information. Personnel and patients should have continual access to the compliance bulletin board. Information posted will have to be regularly reviewed to ensure current data is being provided.
- **Hotline or E-mail:** Practices may implement a compliance hotline or compliance e-mail capability to encourage anonymous reporting directly to the Compliance Officer or compliance contact. The hotline can be an 800 number or separate telephone number established for personnel and patients to verbally report compliance complaints. An e-mail address can be established to receive electronically generated complaints of alleged misconduct or fraudulent behavior or conduct. These systems should not identify the person making contact, record the telephone number or any other data that could result in a breach of informant confidentiality. Practices can also contract with an outside source to provide these services.



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Employ Comprehensive Education and Training

- Always document every training with a training log signed and added to compliance manual
- Every webinar, free or otherwise should be included, if appropriate
- All outside seminars should be documented
- CO should lay out a training plan early in the year according to the calendar



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Enforcing Standards: Consequences and Incentives



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Next, Keep Open Lines of Communication




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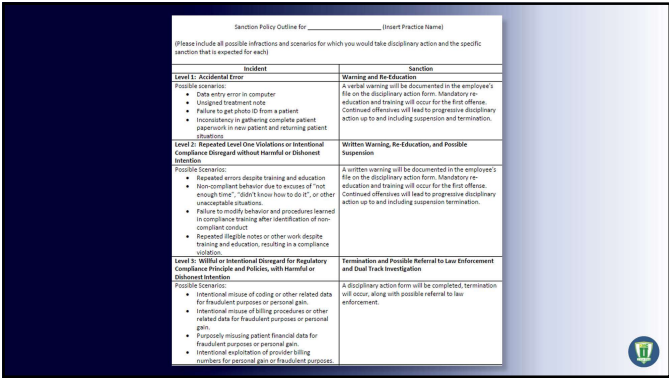
Enforce Disciplinary Standards

- Lay out a sliding scale of discipline to be enforced
- Range from verbal warning and retraining up to referral to law enforcement
- Document, document, document

Follow Up Training Is There For a Reason



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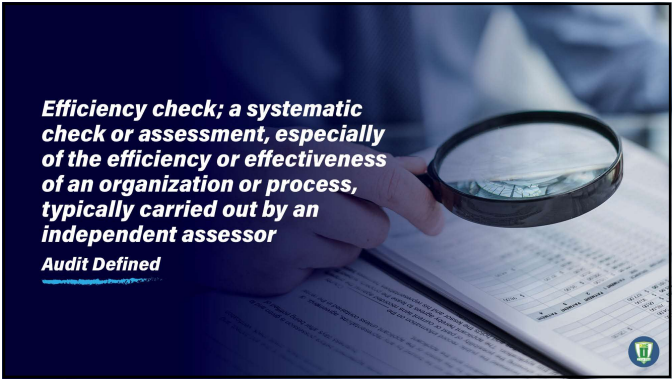
181



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Why Perform Self-Audits?

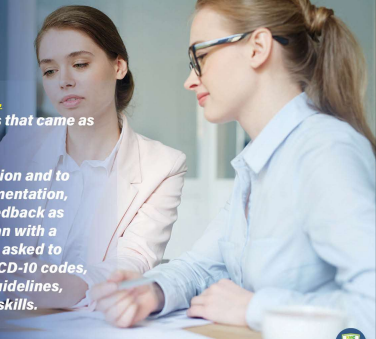
- To identify and correct weaknesses in the patient record documentation to prove intent for being compliant
- To catch errors before they are billed
- To achieve constant improvement



187

Take Action!

- **Revise policies and procedures.** Distribute copies of the updates that came as a result of the audit.
- **Provide additional training in specific areas:** For their education and to improve their coding and documentation, providers receive individual feedback as needed. For example, a physician with a pattern of under-coding may be asked to review the appropriate CPT or ICD-10 codes, as well as the documentation guidelines, to strengthen his or her coding skills.



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Be Prepared by Knowing Ahead of Time



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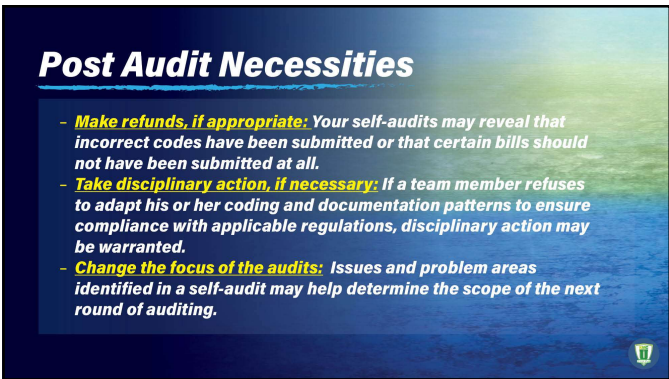
Next, Respond Swiftly to Detected Offenses



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Post Audit Necessities

- **Make refunds, if appropriate:** Your self-audits may reveal that incorrect codes have been submitted or that certain bills should not have been submitted at all.
- **Take disciplinary action, if necessary:** If a team member refuses to adapt his or her coding and documentation patterns to ensure compliance with applicable regulations, disciplinary action may be warranted.
- **Change the focus of the audits:** Issues and problem areas identified in a self-audit may help determine the scope of the next round of auditing.



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Detected Offenses?

- Errors found on audit
- Misbilling
- Missing documentation
- Per Medicare, overpayments refunded within 60 days of discovery



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Document!

Chronological Record of Compliance Incident # 2013-01-1

1/12/13: Patient Mary Smith called and spoke to Mary Jones, very concerned and upset that we were overbilling her insurance. She stated that the EOB from BC/BS for date of service 11/14/12 showed charges for CMT at \$40, 97014 at \$30, and 97012 at \$30. She felt sure that she did not receive therapy on 11/14/12 as it was her birthday and she was just in and out quickly. Because her co-insurance is 20%, she felt that she was overcharged on her recent statement. She said she will not return to the office until the charges are corrected. (Notes copied from the notes section of our software, in Mary's account)

1/14/13: I reviewed the billing and compliance incident, I reviewed the date of the posted charges from 11/14/12. I found that the billing for CMT provided to the center was for CMT, 97014, and 97012. I am not present to indicate that the service was performed. I met with Dr. Brown, physician, and he requested that I double check the therapy log book in the therapy bay. I met with Dr. Brown on the date in question. After meeting with Dr. Brown, we concluded that there was no service provided.

1/15/13: Met with Dr. Brown to discuss the charges. We reviewed the charges and the routing slip as well as the scanned copies of the routing slip from 11/14/12. The routing slip indicated that she only received CMT that day. However, a charge entry was posted as all three services. Dr. Brown stated that she does use macros, and the feature in the software that allows her to input the charges is a macro so that the entry takes less time. She cannot remember exactly what she did on 11/14/12, but did state that she has caught herself making that error other times. She said that the End of Day Balancing Sheet could balance if she added all the routing slips and they didn't add all the services in the computer. When we looked at the routing slip, we found that she incorrectly placed the date of service charges in the lower left corner total on the routing slip. However, only one service was marked as completed. We discovered that this was a human error. When asked how often she feels this happens, she admitted that it could slip through on busy days. I copied the routing slip, the End of Day Balancing Sheet and have included them in this record as evidence of the human error.

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And If You Find Someone On the List

- Contact your compliance expert immediately
- Doctor in Maine-CA was part of another practice
- Doctor in Kansas-Same name as a bad actor

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Verify All Employees

Exclusion List

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Creating a Policy

Employee Clearance

Scope:
Applies to all existing employees processed and all new employees.

Purpose:
To ensure all employees of the health center upon hire and annually to verify that they are not on the OIG exclusion database. NOTE: New hires should be checked monthly for the first 3 months of employment.

Definitions:

Term	Definition
OIG	Office of the Inspector General usually in healthcare referring to the OIG for the Department of Health and Human Services (HHS)
Excluded Individual	Any individual identified as part of the OIG exclusion list.

Policy:
It is the policy of this office to hire employees who are eligible to work with federal programs such as Medicare, and do not appear on the OIG Exclusion of Excluded Individuals. To the extent of employees or contractors working at [HHS] [HHS] [HHS] [HHS] are reviewed through this exclusion database before entering an office of employees, and then periodically throughout their tenure in the office.

The human resource (HR) department, Compliance Contact Officer (CCO) or authorized personnel at [HHS] [HHS] [HHS] [HHS] will review the exclusion database prior to any offer of employment, all new employees will be checked weekly for the first three months of employment, and then quarterly for the first year of employment and all employees will be checked annually after that. The results of these reviews will be in the [HHS] [HHS] [HHS] [HHS] for each employee, with a copy to the [HHS] [HHS] [HHS] [HHS] Compliance Policy manual.

Any individual who appears on this list is subject to termination, per the employment agreement, or restriction from performing or providing services as an employee of the office.

Procedures:

- All parts of the Exclusion checks will be conducted prior to employment, monthly for the employee's first 3 months, then quarterly for the remainder of the employee's first year. Once the first year is complete, the Exclusion check will be run annually.
- Check new employees by checking the OIG and SAMR lists (included below) and enter the employee's first and last names in the search bar. If the employee's name does not appear, the exclusion check has been successful.
- For OIG: [https://oig-exclusions.hhs.gov/](#)
- For SAMR: [https://sam.gov/](#)
- To check for State exclusions, visit the [State] [State] [State] [State] and open the list of Suspended/Revoked License List. If the employee's name does not appear, the State exclusion check has been successful.

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OIG.HHS.GOV is the Website

- Bookmark this site
- Initial review, all new employees, and then periodically

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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

DATA ANALYSIS

199

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

202

You're Going to Find Some Things Wrong

200



THE PRACTICE PERFORMANCE ANALYSIS

Your Practice's Health Check-Up for Revenue, Compliance and Efficiency

WHAT'S INCLUDED IN YOUR ANALYSIS?

- Practice Billing Profile (PBP)
- Fee Analysis
- Proactive Chart Review (PCR)
- Accounts Receivable (A/R) and Cash Flow Analysis

Use code **AMI100** at checkout to enjoy these savings!



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(NORMALLY \$499 EACH)



203

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



Your Business

- VISION**
 - 8 QUESTIONS
 - SHARED BY ALL
- PEOPLE**
 - RIGHT PEOPLE
 - RIGHT SEATS
- DATA**
 - SCORECARD
 - MEASURABLES
- PROCESS**
 - DOCUMENTED
 - FOLLOWED BY ALL
- TRACTION**
 - ROCKS
 - MEETINGS
- ISSUES**
 - ISSUES LIST
 - IDS

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OIG Essentials: Building Your Compliance Core

Begin to build a strong, sustainable compliance program with KMC University's OIG Foundational Compliance Implementation and Training Program.

WHAT'S INCLUDED?

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- Compliance Implementation Materials

ONLY \$699/MONTH
MINIMUM 6 MONTHS
*Additional providers' Baseline Chart Audit \$999 each.

SCAN THE QR CODE... LET'S GET STARTED!



<http://kmcuniversity.com/OIG-essentials>



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