Be Prepared: Planning and Implementing an Effective Compliance Program
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Student-Doctor Networking Reception
Saturday September 16
5:00-7:00 pm
Event sponsored by: Palmer College of Chiropractic
Students are our future. Join us for drinks and appetizers. Doctors meet your potential new hires. Students, come and introduce yourselves to potential employers. Now is the time to network.

Relax after a long day of classes. The winner of the Dr. Kenneth Luedtke Scholarship will be announced. Don’t miss this opportunity to connect with the next generation of chiropractors.

Thank you to my mentors
Mario Fucinari DC, MCS-P, CCSP
www.AskMario.com
Evan M. Gwilliam, DC MBS BS CPC CCPC NCICS CCCPC CPC-IMCS-P CPMA
Vice President ChiroCode Institute
 todays Outline

Policies and Procedures
- Implementing written policies and procedures
- Review Code of Conduct
- Understanding Fraud and Abuse
- 7 Elements of Compliance Program
  - Implementing written policies and procedures
  - Designating a compliance officer and compliance committee
  - Conductingaffordable training and education
  - Developing effective lines of communication
  - Conducting internal monitoring and auditing
  - Retaining elements through well-publicized disciplinary guidelines
  - Responding promptly to detected problems and undertaking corrective action
- Employee Job Descriptions
- Documentation Review (Entrance Forms, Implied Consent)
- Advance Beneficiary Notice (ABNs)
- Outcome Assessment Tools (OATs)

Today's Outline

Policies and Procedures
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Record Keeping, Documentation Coding

- Learn how payers define and use "medical necessity"
- Learn how to avoid the most common errors and audit targets
- Documentation Overview
  - Learn the elements of a complete standardized set of medical and treatment codes
  - Become familiar with EHR documentation elements
  - Documenting Diagnosis
    - Learn how to document diagnosis codes to match the codes
    - A complete and accurate diagnosis
    - Be able to set up and maintain your codes
  - Documenting Treatment Plans
    - Learn how to set up and maintain your codes
    - Documenting for treatment (daily)
  - False Claims Act
  - CPT documentation elements
  - Documentation for treatment (daily)
  - False Claims Act

Have a Question?

Call Tammy at the WCA Help Desk

Member Benefit.
Monthly Webinars
Compliance and Integration

- Designating a compliance officer and compliance committee
- HIPAA
- Risk Analysis
- Physical Safeguards Requirements
- Up coding/Down Coding and Diagnosis Related Group Diagnosis
- Unbundling services
- Duplicate billing
- Anti-Kickback Statute
- Joint ventures, Stark Law and financial arrangements
- False cost report
- Mercy Conference Guidelines
- Economics
- OIG Work Plan
- Patient Protection and Affordable Care Act (Public Law 111-148)
- Responding promptly to detected problems and undertaking corrective action

Do You Feel Like This?

Or this this?

Does Your Business Deserve the Same Focus Your Patients Do?

Reduce Your Risk

- Scrutiny and accountability in Healthcare are up
- Affordable Care Act and other state-level documentation and compliance rulings make it more critical than ever to decrease your practice risks.
Learn 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.

What is HHS?

- The United States Department of Health and Human Services (HHS), also known as the Health Department, is a cabinet-level department of the U.S. federal government with the goal of protecting the health of all Americans and providing essential human services.
- Its motto is “Improving the health, safety, and well-being of America”. Before the separate federal Department of Education was created in 1979, it was called the Department of Health, Education, and Welfare (HEW).

What is FBI?

- The Federal Bureau of Investigation, formerly the Bureau of Investigation, is the domestic intelligence and security service of the United States, and its principal federal law enforcement agency.

Who is the OIG?

- Office of Inspector General’s (OIG) mission is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries.
- The Office of the Inspector General (OIG) investigates criminal activity for HHS.
- The special agents who work for OIG have the same title series “1811”, training and authority as other federal criminal investigators, such as the FBI, ATF, DEA and Secret Service. However, OIG Special Agents have special skills in investigating white collar crime related to Medicare and Medicaid fraud, abuse, and other insurance crime.

To Summarize

- FBI
  - Police for all Insurance and Cash Patients
- OIG
  - Police for Medicare, Badger Care, and other government programs

Government’s Healthcare Oversight

- HHS OIG is the largest inspector general’s office in the Federal Government, with approximately 1,400 dedicated to combating fraud, waste and abuse and to improving the efficiency of HHS programs. A majority of OIG’s resources go 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.
OIG Strategic Plan 2014-2018

- The OIG has a clear and narrow focus for success:
  - Goal One: Fight Fraud, Waste, and Abuse
  - Goal Two: Promote Quality, Safety, and Value
  - Goal Three: Secure the Future
  - Goal Four: Advance Excellence and Innovation

OIG 2017 Work Plan

- Subsequent OIG work identified unallowable Medicare payments for chiropractic services:
  - Part B pays only spinal manual manipulation to correct subluxation
  - If there is neuro-musculoskeletal condition in which manipulation is appropriate treatment

- Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply With Medicare Requirements
  - Most Medicare payments for chiropractic services did not comply with Medicare requirements.
  - Over $358.8 million, or approximately 82 percent, of the $438.1 million paid by Medicare for chiropractic services was unallowable.

We recommended that CMS do the following, which could have saved Medicare an estimated $358.8 million for 2018:

- Determine a reasonable number of chiropractic services that are necessary to actively treat spinal subluxation and implement a system edit to identify services for review in excess of that number
- Determine a reasonable limit for the number of chiropractic services that Medicare will reimburse, take appropriate action to put that limit into effect, and implement a system edit to disallow services in excess of that limit
- Improve education of chiropractors on Medicare coverage requirements for chiropractic services and the proper use of the AT modifier to ensure that only medically necessary chiropractic services are billed to Medicare
- Specifically identify significant obstacles to developing a more reliable control for identifying maintenance therapy and work to establish such a control.
Strategic Health Solutions has been contracted to perform and provide medical review functions of Medicare and Medicaid programs.

Strategic Health is currently performing medical review of records through the project 14P0434 for Chiropractic Services.

Documentation will be reviewed for compliance on such issues as medical necessity, maintenance care and signature requirements.

CMS will direct claims adjustments and recoupment efforts.

Medicare Audits

- Required by law
- To confirm that services are covered and are medically necessary
- Applies to Par and Non-Par doctors
- Performed by all carriers as well as commercial carriers
- HIPAA audits, Department of Professional Regulations and Board of Examiners are also done

IF YOU SEE MEDICARE PATIENTS, YOU CAN NOT OPT OUT OF MEDICARE!

How do you Compare?

Handout for Doctors

Look up your profile at:


- Search the database by provider name, specialty and location to see the types and number of procedures performed and the amounts paid to each provider by Medicare.
Chiropractic Is Back In The Medicare Crosshairs Again

Reference

The risk is a familiar one you know all too well: The Office of Inspector General (OIG) is going after chiropractors.

The OIG has started another round of audits to recapture money paid out inappropriately to chiropractors by the Centers for Medicare and Medicaid Services (CMS) system. And if you think this does not involve you, think again—you may be surprised by this brand-new risk.

Did you Know...
For every $1.00 Spent on Auditing Chiropractors Auditors Receive $12.00

The following report was posted on the OIG website
1 In this report, it is stated that the OIG has a list of targeted chiropractors for the same or similar actions.
The aftermath

- The Michigan chiropractor identified in the above report now owes CMS a repayment of nearly $650,000.
- The summary shows the OIG reviewed 100 Medicare services.
- Over 10 years.

They determined 92 of the 100 were not allowable because the medical records did not support medical necessity.

- They also stated overpayments occurred because they did not have adequate policies and procedures to ensure medical necessity of services billed to Medicare was adequately documented.

They then extrapolated the findings of 100 cases to the total services rendered, resulting in a demand to the office to repay $339,625.

The OIG then considered the chiropractor’s rebuttal but overruled it, letting stand their recommendation to return the money and get proper policies in place.

The report further states that of $466 million paid out to chiropractors they reviewed, approximately $180 million was paid due to error or fraudulent billing.
The road to recoupments

- Chiropractors didn’t become a target overnight for potentially hundreds of millions of billed dollars to be returned.
- Those who work in the area of HIPAA compliance services have seen this coming for a long time.

Even more tellingly, Medicare was specifically funded for the years 2014 and 2015 to investigate chiropractors for instances of inappropriate and illegal billing.
- Advance beneficiary notice (ABN) compliance is more important than ever, and it’s necessary to release patients when documentation no longer supports active care under Medicare’s definition.
- Even though these are not HIPAA matters, they do constitute an imminent threat to chiropractors.

Chiropractic has consistently ranked number one for errors.

- The reasons for our errors are ranked as follows:
  - #1 Reason for Errors resulting in improper payment
    - Incorrect coding
  - #2 Reason for Errors resulting in improper payment
    - Medically unnecessary services
      - (maintenance care)
  - #3 Reason for Errors resulting in improper payment
    - Insufficient
    - Documentation
Medical Review (MR) Chiropractic

- MR reviewed Chiropractic claims - 98941
  - Between June 1 to August 31, 2016
  - 2,555 claims with improper payment rate of 88.3%
  - Non-responder rate of 34.2%

- Top Errors with policy requirements not met: 81%
  - Treatment plan does not include specific treatment goals
  - No objective measures to evaluate treatment effectiveness
  - Treatment plan did not include recommended level of care
  - Subluxation requirements not met • 2 out of 4 criteria of P.A.R.T.
  - No documentation of specific treatment given during visit
  - Failure to return records: 13.7%

- Core problem list for denial reasons:
  - Treatment plan does not include specific treatment goals
  - No objective measurements to evaluate treatment effectiveness
  - Treatment plan does not reflect treatment effectiveness
  - Not enough diagnosis codes on claim or in documentation for spinal levels adjusted/billed
  - Patient history/present illness requirements not met
  - Mechanism of trauma not included in documentation
  - History/present illness elements did not bear direct relationship to level of subluxation

- Need more than “lumbar” verbiage
  - “C-4, T-2, L-3, etc.”
  - Area, if implies certain bones
  - Individual vertebrae must be listed, not entire region
  - Missing “specific” treatment goals
  - Must be specific (e.g. “pain level will be a 3/10 in three weeks”) – Treatment goals cannot be general in nature such as “reduce pain and restore normal joint function and muscle balance”
  - Claims not denied because of diagnoses

- Documentation – Signatures
  - Handwritten or electronic signature accepted
  - Must be signed prior to billing
  - Stamp signatures not acceptable
  - Exception for physical disability
  - CR 8219 dated June 18, 2013
  - Physicians can not add late signatures
  - Except short delay during transcription
Use signature attestation

- No signature on progress/treatment note submitted – attestation sample
- “I, [name of doctor] ________, hereby attest that the medical records entry for the date of service _______ accurately reflects signature/notations that I made in my capacity as a D.C. when I treated/diagnosed ___________________________.
- I do hereby attest that the information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.”
- Signature: __________
- Date Form Completed __________

CERT Chiropractic Documentation Checklist

- Audit request checklists
- CERT requests Chiropractic Documentation

Receive Documentation Requests?

- If any post pay audit contractor requests
  - Fax timely all specific records/documentation
  - Send to contractor timely with:
    - Chief complaint/Plan of Care
    - Chart/Treatment notes
    - Proof of medical necessity
    - Physician notes
    - Documentation must support CPT level
    - Signature

Reminders

- Concierge Practice Not Allowed
- “Boutique Medicine or Concierge Care”
  - Per Office of Inspector General (OIG)
  - Violation of Assignment agreement
  - Includes charging patient “on call” retainer to coordinate care with other providers
  - Comprehensive assessment
  - Plan for optimum health/patient care

Resources

- CMS (IOM) Benefit Policy Manual
  - http://www.cms.gov/Manuals/IOM/
  - Publication 100/02, Chapter 15
  - Section 38.5, Chiropractic Coverage
  - Section 240.1, Chiropractic Services-General
  - Publication 100-04, Chapter 12, Section 220
  - Publication 100-08, Chapter 5, Section 3.3.3.4

YouTube Videos

- Watch “Improving the Documentation of Chiropractic Services” (20 mins)
  - https://www.youtube.com/watch?v=tMiw1X9KvDA&feature=youtu.be
- Watch ACA video “Just Tell Me What To Do”
  - https://www.youtube.com/watch?v=XlPbtmlv5Ic

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A provider must begin using the most recent version of the form no later than June 21, 2017.

All ABNs with an expiration date of prior to 03/2020 that are issued on or after June 21, 2017, will be considered invalid.

The form is considered by CMS to be an Office of Management and Budget (OMB) form and therefore must periodically be reviewed and renewed.

**What is ABN?**
- It is a customized written document used to inform a Medicare patient that a specific service(s) ordered for their care may not be deemed "reasonable and necessary".
- ABN indicates the patient's agreement to accept responsibility for payment in the event Medicare denies payment.
- For chiropractic, reason for non-coverage is generally due to services not being deemed medically reasonable and necessary per Medicare guideline.
Purpose of ABN

- Provide Medicare beneficiaries with advance notification of their financial responsibility for any known or potentially non-covered services
- ABN indicates the reason(s) why it is likely that Medicare payment will be denied for that service(s)
- Non-covered services, as defined by Medicare, are never covered by Medicare and are the patient's responsibility to pay. Potentially non-covered services may or may not be covered by Medicare, depending on diagnosis used.
- So it requires a signed ABN.

General Rules

- Patient's/patient's representative's signature must be obtained on the ABN which Medicare excludes due to medical necessity as defined by CMS
- ABN form must be signed prior to the services being rendered. (If it is signed after services or if a blank ABN is signed it is not valid)

2 Sheets to Use
Med Sign 1X a Year Form

Or Write your Own

ABN Form
Patients rights

- The patient is not responsible for any of the charges until Medicare has made a determination regarding the medical necessity for the service(s).

Not acceptable

- Pre Signed / and or dated
- Unsigned and un dated ABN form
- Reason written in hard to understand language
- Reason written in Foreign language
- Blank ABN’s to complete “later on”
- Incorrect name used on ABN
- SS # used as ID
- Cannot be used to bill a beneficiary for services Medicare considers bundled into other charges.

Correct completion of ABN form

- Patient’s name must be filled in completely. DO NOT PUT PATIENTS LABEL STICKERS ON THE FORM
- Identification number is to help link the notice with a claim. You can use the account number but the field is optional. The beneficiary’s Medicare number or SS should not be offered.
- Description of service(s) that may be denied must be understandable to the patient.
- An explanation of the reasons(s) for potential denial. (Reasons such as “we don’t know why they might not pay for it” are not specific enough.
- Estimated cost column: the estimated amount must be listed. Use good faith estimate do not leave blank.
- Must check one of the boxes for the option.
- In Additional information notifies can use the space to record other payer information.
- The patient or guarantor must sign and date the form.

A&B filing

- Original signed and dated ABN is filed in the clinic chart or if it is an EMR it should be stored in a retrievable fashion.
- A copy is to be provided to the patient.
- A copy is to be attached to the patient’s corresponding charge ticket (Super Bill) for charge entry purposes.

Test Your Self scenarios

Medicare Part B-Active Care
1st Visit

What Forms to use?

Have the Patient sign the 1X a year voluntary ABN for non-covered services (ex: exam, x-ray, therapies...)
Test Your Self scenarios

Question #2
Medicare Part B
Maintenance Care

What Forms to use?
ABN

Question #3
Medicare Part C/Advantage Plan
In Network
Active Care

What Forms to use?
Have the Patient sign the 1X a year voluntary ABN for non-covered services (i.e. exam, x-ray, therapies...)

Test Your Self scenarios

Question #4
Medicare Part C/Advantage Plan
In Network
Maintenance Care

What Forms to use?
Not voluntary in nature as Part C Plans follow CMS guidelines.
Contact The Insurance Company and utilize their In-house ABN as the CMS form in Not Valid.

Question #5
Medicare Part C/Advantage Plan
Out of Network
Active

What Forms to use?
Have the Patient sign the 1X a year voluntary ABN for non-covered services (i.e. exam, x-ray, therapies...)

Test Your Self scenarios

Question #6
Medicare Part C/Advantage Plan
Out of Network
Maintenance Care

What Forms to use?
Have the Patient sign the 1X a year voluntary ABN for non-covered services (i.e. exam, x-ray, therapies...)
Contact The Insurance Company and utilize their In-house ABN as the CMS form in Not Valid.

Medicare Modifiers

It is Critical for every office to clearly understand the proper use of Modifiers. Currently the only covered codes by Medicare are CMS Codes 0942 and 9942 When they are "Medically Reasonable and Necessary."
Medicare Modifiers

Here are the basics for coding and billing modifiers

NO Modifier Appended

When no Modifier is used, this indicates Maintenance care. Without appending an appropriate modifier, neither Medicare of the Patient would be responsible for payment of this Service.

AT Modifier appended to Spinal CMT

Active Treatment for the corrective phase of acute or chronic care. The Provider is informing Medicare that this procedure meets definition of medical necessity.

GA Modifier appended to Spinal CMT

Your Declaration that a Waiver of Liability Statement (for Medicare, this is the ABN) has been properly delivered as required by payer policy.

GZ Modifier appended to Spinal CMT

You Failed to deliver a mandated ABN, as is required by payer policy. In such cases, the patient does not have to pay. Please note that some providers have reported that the use of this Modifier Results in an AUDIT!

GY Modifier appended to Spinal CMT

Must be appended to all statutorily non-covered services to ensure the claim will deny per Medicare policy. A Denial may be Necessary 1.) to allow for appropriate billing of supplemental/secondary insurance or if the patient has requested this non-covered item/service to be submitted to Medicare on their behalf for evidence of non-coverage.

Use it for 98943,99202,99212
**Key Points**

"Blanket" ABNs are not permissible

The ABN is date-of-service specific, meaning that you can’t just have one signed every once in a while. You have to have a reasonable expectation that that particular visit is not payable.

Once an ABN has been signed for the purpose of indicating maintenance therapy, that ABN is valid for that series of maintenance treatment, until there is an exacerbation or any provision of active care, for up to one year. Once there is an exacerbation or new active treatment, any maintenance care following would require a newly delivered ABN.

The proper delivery of an ABN is very formalized and detail-specific.

The release of the most recent ABN form does not automatically mean doctors of chiropractic no longer have to file maintenance care claims. If the beneficiary chooses to select the “Option Z” box, indicating they wish Medicare not be billed, then you can NOT bill Medicare. Please note this is a decision to be made by the beneficiary; you should not influence their choice.

The new form, in and of itself, does NOT mean doctors of chiropractic “no longer have to bill for maintenance care.” Aside from the exception above, maintenance care must still be filed. Doctors must verbally review the form with patients prior to their signing.

*Original signed and dated* ABN is filed in the clinic chart or if it is an EMR it should be stored in a retrievable fashion.

*• A copy is to be provided to the patient.*

*• A copy is to be attached to the patient’s corresponding charge ticket (Super Bill) for charge entry purposes.*
The OIG presently recommends seven basic components to a compliance program:

- Implementing written policies, procedures, and standards of conduct.
- Designating a compliance officer and committee.
- Conducting effective training.
- Developing effective communication.
- Conducting internal monitoring and auditing.
- Enforcing well-publicized disciplinary guidelines.
- Responding to detected offenses and undertaking corrective action.

Key Points

**Use the 2 Different Forms**

ABN 1 x A Year

ABN Ticket

It's a Medicare World

Documentation

- If you had to retire tomorrow... Could another doctor pick up your notes and continue with care?

Chiropractic Services LCD

- Local Coverage Determination (LCD) policy -十分重要 that all Chiropractors read!

Spinal Manipulation Coverage

- Treatment of the spine, limited specifically by manual manipulation (use of hands), to correct a subluxation
- Demonstrated by x-ray or physical exam
- Hand-held devices allowed (controlled manually)
- No additional payment (e.g., ProAdjuster)
- No other diagnostic/therapeutic covered
- When furnished/ordered by chiropractic physician
Chiropractic Manipulative Treatment (CMT) Regions

- Cervical – C1-7
  - Including atlanto-occipital joint
- Thoracic – T1-T12
- Lumbar – L1-5
- Sacral – Sacrum, coccyx
- Pelvic – Including sacroiliac joint (SI)

Dynamic Thrust

- Dynamic thrust is therapeutic force delivered during manipulation in involved anatomic region – Relative "contraindication" condition adding significant risk of injury to patient from dynamic thrust; discuss with patient and record in chart; not ruling out use

Dynamic Thrust

- Several relative contraindications to dynamic thrust:
  - Articular hypermobility
  - Severe demineralization of bone
  - Benign bone tumors (spine)
  - Bleeding disorders and anticoagulant therapy

Coverage Categories

- Acute – New Injury
- Chronic – May not resolve completely
- Exacerbation – Condition flare-up
- Recurrence – Previous condition returns after 30 days/more

Excluded Chiropractic Services

- Beneficiary responsible; never covered
- May bill patient with/without billing Medicare or optional bill appending modifier GY
- Secondary crossover insurance may allow

Claim Requirements
Mandatory Claims Submission
- Effective September 1, 1990
  - All providers must submit Medicare claims for covered or potentially covered services (98940-98942)
  - On behalf of Medicare beneficiaries
  - Providers may not charge for this paperwork
- IOM 100-04, Chapter 1, Section 30 – http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf

Mandatory Claim Submission
- Not mandated to treat/see Medicare patients, but once service/procedure provided, must bill
  - Only the 98940-98942 codes
  - Including maintenance therapy • Unless ABN Option 2 marked
  - Not allowed to “Opt-Out” of Medicare
  - If see a Medicare patient, must enroll
  - Timely claim filing
    - 12 months from date of service
    - Provider may not bill patient if deadline not met

CPT Manipulation Codes
- 98940 CMT; spinal, one to two regions
- 98941 CMT; spinal, three to four regions
- 98942 CMT; spinal, five regions
- 98943 – noncovered Extraspinal, one or more regions

Primary ICD 10 Policy Diagnoses
- Current Segmental and Somatic Dysfunction of a Region
  - M99.00 Somatic and Segmental Dysfunction of the Head
  - M99.01 Somatic and Segmental Dysfunction of the Cervical
  - M99.02 Somatic and Segmental Dysfunction of the Thoracic
  - M99.03 Somatic and Segmental Dysfunction of the Lumbar
  - M99.04 Somatic and Segmental Dysfunction of the Sacral
  - M99.05 Somatic and Segmental Dysfunction of the Pelvic

Secondary Diagnosis Code
- Every claim for every region must have
  - Primary and Secondary diagnosis
  - Secondary is Neuromusculoskeletal condition for treatment
  - why the patient came in
  - Example...

<table>
<thead>
<tr>
<th>Category</th>
<th>Treatment</th>
<th>Chief Complaint</th>
<th>Secondary Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Short Term</td>
<td>Tension Headache</td>
<td>G44.209</td>
</tr>
<tr>
<td>2</td>
<td>Moderate</td>
<td>Back Muscle Spasm</td>
<td>M82.830</td>
</tr>
<tr>
<td>3</td>
<td>Longer</td>
<td>Post Laminectomy</td>
<td>M96.1</td>
</tr>
</tbody>
</table>

Initial Treatment Date (ITD)
- Paper Billing
  - MM/DD/YYYY or YYYYMMDD
  - No qualifier needed
- Electronic Billing
  - Loop 2400 DTP03 = CCYYMMDD
  - Loop 2400 DTP10 = use qualifier 444 for initial treatment
Item 14 (ITD) = first “Episode of Care” date
If patient seen March 2, 2016 for neck pain
Bill 03/02/2016 (paper) or 20160302 (electronic)
Patient exacerbates neck injury and revisits Nov 3, 2016
Bill 11/03/2016 (paper) or 20161103 (electronic)
Paper (no qualifier) or electronic (needs qualifier 454)

Item 19
X-ray date and/or miscellaneous descriptions
6-digit or 8-digit date with optional verbiage
Additional diagnoses if needed
Note: If physical exam performed, no need to add date in Item 19
Make sure documentation reflects

Diagnoses for Each Region (Primary/Secondary)
Item 21 = Diagnosis
- No decimals or descriptions
- Must be to highest level of specificity
- Up to 12 available
Each region billed requires both diagnoses
- One primary and corresponding secondary
List clinically significant primary/secondary
Document additional diagnoses in clinical record
E.g., A = M99.00 (primary) b = G44.209 (second)

Additional Claim Highlights
Item 24E
- Primary diagnosis (alpha) linked from Item 21
- Enter one correlated alpha only
Item 24J
- Individual practitioner NPI
Item 33A
- Group or Solo NPI
- 10-digit numeric number

Active Corrective Treatment
- When providing active/corrective treatment, must append AT modifier
- CPT codes (98940 – 98942)
- Very important that the Chiropractor determines when patient moving from improving (AT) to Maintenance Therapy (GA)
- In post pay reviews, documentation could indicate Maintenance Therapy and monies recouped
- cannot collect from the patient

Chiropractic Claim Summary
- Must include the following:
  - Date of service
  - Place of service
  - Procedure code
  - Initial date for this course of treatment
  - Subluxation(s)/regions • Primary diagnosis(es)
  - Symptom(s) or conditions • Secondary diagnosis(es)
  - Chiropractor NPI
- Failure to report may result in claim denial
Maintenance Therapy & ABN

- Treatment considered maintenance when chiropractic treatment supportive, not corrective
- When further clinical improvement cannot be expected from continuous ongoing care
- Not a Medicare covered service, but must bill
- Maintenance includes services that seek to:
  - Prevent disease
  - Promote health
  - Prolong/enhance quality of life
  - Maintain/prevent deterioration of chronic condition
- Mandatory Claim Submission rules
- Requires providers to bill Medicare, even if service might deny
- (98940, 98941 or 98942)
- Obtain ABN
- Append GA modifier
- Do not append AT modifier
- Never bill AT and GA modifiers on same line

Extended Course of Treatment

- Single ABN (up to one year) acceptable:
  - ABN identifies all items/services and duration of period of treatment
  - No changes to treatment
  - Services are not added/deleted after treatment
  - ANY changes require new ABN
- Is ABN used appropriate?
- Is ABN completed correctly?
- Does documentation support use of ABN?
- Medical Necessity
- Maintenance Therapy

Missed Appointments

- Providers may charge nominal fees for missed appointments
  - If charge all patients and never bill Medicare
- Providers cannot charge Medicare beneficiary more than non-Medicare patient
- Medicaid/Social Security Act (SSA) regulation (Section 1128a) found at http://www.ssa.gov/OP_Home/ssact/title11/1128.htm

The date of the story: Box 14

- This box is used to report the onset of acute symptoms for a current illness or condition or that the services are related to the patient’s pregnancy. There are two valid qualifiers for this box, these qualifiers and their guidelines are listed below.
  - 431 (Onset of Current Symptoms or Illness) - This information is required for the initial medical service or visit performed in response to a medical emergency when the date is available and is different than the date of service. The date entered in this box should not be the same as the date of service. If the dates entered are the same the claim will be returned unprocessed.
  - 484 (Last Menstrual Period) - This information is required when, in the judgment of the provider, the services on this claim are related to the patient’s pregnancy.
- Treatment plans only 90 days… if over HUGE RED FLAG!!!
Medical Necessity

“Services or items reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member”

Quick Check
1. Does the patient have a complaint in the area treated?
2. Are there objective findings to explain the cause of the complaint?
3. Does the record show a clear plan to correct the problem?
4. Does the record show progress towards measurable goals?

Exam Discussion
- 10-15 Visits or Every 30 days
- Up to Clinical Decision

Evaluations vs. Treatments

Evaluations vs. Treatments

Treatment visit (the plan is carried out)
- Update patient-centered measurable subject and objective information
- Assess patient specific functional progress
- Describe procedures and where the patient is in the plan

To get the whole story, a reviewer would need the evaluations on either side of the treatments. This describes the entire episode of care rather than an isolated treatment.

EPISODE OF CARE

EPISODE OF CARE
Manipulation + Evaluation and Management

- The CPT codes include a premanipulative patient assessment (98764).
- Additional Evaluation & Management (E/M) services may be reported separately using modifier -25 if the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure.

Change Dx

- Change Dx every 30 day or 12-15 visits.
- Not necessary.
- Duration and frequency not exceed 30 days.

New things to Consider

- Documentation of how the days treatment fits within the plan of care (eg visit 4 of 7) and any way the treatment plan is being changed.
- You must document the actual segments that you adjusted.
- Document the response to the adjustment. Patient tolerated the procedure well; without innocent.

Z91.19

- Patient's noncompliance with other medical treatment and regimen.
- If patient skips a day, and it was visit 5 of 12, the next time they come in they are on visit 6 of 12.

Medical Necessity

- Title XVIII of the Social Security Act. Section 1862(a)(1)(A) clarifies no payment may be made for any expenses incurred for items or services not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Medical Necessity

- Title XVIII of the Social Security Act. Section 1862(a)(1)(A) clarifies no payment may be made for any expenses incurred for items or services not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- Demonstrate significant health problem of neuro-musculoskeletal condition
- Statement of “pain” alone is insufficient
- Need chief complaint
- Pain location must be described
- Whether particular vertebra producing pain
- Direct therapeutic relationship to patient’s condition

- Reasonable expectation of recovery
- Arrest/retard deterioration in condition
- Within reasonable/predictable period of time
- Treatment of the spine, limited specifically by manual manipulation (use of hands), to correct subluxation
- No additional device payment

**Treatment Parameters**

- Acute subluxation (e.g., strains or sprains)
- May require treatment for months
- Some conditions need less treatment
- First several days, treatment may be frequent
- Decreasing as improvement achieved

- Chronic spinal joint condition exists a longer period of time
- Usually, joints have already “set” and fibrotic tissue developed
- Condition may require longer treatment time
- Not necessarily with higher frequency
- Never covered - room or ward fees

**Active vs. Maintenance Treatment**

- Goal driven
- Treatment plan
- Individualized
- Short term
- Long Term
- Measurable progress towards goals
- When providing active/corrective treatment, must append AT modifier
- CPT codes only (98940–98942)
- Otherwise, considered maintenance therapy
Maintenance Therapy

- Maintenance services:
  - Preventive
  - Promote health
  - Prolong or enhance quality of life
  - Maintain/prevent deterioration

- When further clinical improvement cannot be expected from continuous ongoing care:
- Treatment is considered maintenance therapy when chiropractic treatment is supportive, not corrective
- Not covered by Medicare, but must bill

Mandatory Claim Submission
- Requires providers to bill Medicare, even if service might deny (98946, 98941 or 98942)
- Obtain ABN
- Append GA modifier
- Never bill AT/GA modifiers on same line

Documentation Guidelines

- Initial Visit

- Documentation Medical Necessity

- P.A.R.T.

- Documentation Somatic and Segmental Dysfunction

- Requirements apply whether subluxation demonstrated by x-ray or physical examination:

- Both participating and non-participating providers

- Document exact bones involved

- Demonstrate a subluxation based on physical examination, two of the four criteria mentioned under the above physical examination list are required, one of which must be asymmetry/misalignment or range of motion abnormality.
1. **Pain/Tenderness**

   Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation, provocation, etc. Furthermore, pain intensity may be assessed using one or more of the following: visual analog scales, algometers, pain questionnaires, etc.

   **Examples of standardized pain assessment tools include:**
   - Brief Pain Inventory (BPI)
   - Faces Pain Scale (FPS)
   - McGill Pain Questionnaire (MPQ)
   - Multidimensional Pain Inventory (MPI)
   - Neuropathic Pain Scale (NPS)
   - Oswestry Disability Index (ODI)
   - Roland Morris Disability Questionnaire (RMDQ)
   - Numeric Rating Scale (NRS)
   - Visual Analog Scale (VAS).

   **Important:** The name of the standardized tool used to assess the patient’s pain must be documented in the medical record.

---

2. **Asymmetry**

   Asymmetry/misalignment — sectional or segmental level

   Asymmetry/misalignment may be identified on a sectional or segmental level through one or more of the following: observation (posture and gait analysis), static palpation for misalignment of vertebral segments, diagnostic imaging, etc.
• P.A.R.T.
R
Range of Motion

Range of Motion Abnormality
Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and Range of motion abnormality - Range of motion abnormalities may be identified through one or more of the following: motion, palpation, observation, stress diagnostic imaging, range of motion measurements, etc.

• P.A.R.T.
T
Tissue

Tissue, tone changes in skin, fascia, muscle, ligament
Tissue, tone changes using descriptions pertaining to the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament. Tissue/Tone texture may be identified through one or more of the following procedures: observation, palpation, use of instruments, tests for length and strength etc.

To demonstrate a subluxation based on examination
Two of the Four Criteria
Must be

Asymmetry
Or
Range Of Motion

P.A.R.T.
The Consultation

- Symptoms causing patient to seek treatment (Chief Complaint)
- 99203 should show PHx, Family Hx, Social Hx
- Family History

Patient History
- Chief complaint
- Patient symptoms why seeking chiropractic treatment
- Has patient had prior chiropractic treatments?
- Symptoms are direct relationship to subluxation level

Present illness may include:

M, O, P, Q, R, S, T

Mechanism of Trauma
- Onset, duration, intensity, frequency, location and radiation
- Provoking and Palliative Factors
- Prior interventions, treatments, medications, secondary complaints

Quality and character of Symptoms/problem
- Radiation of symptoms
- Severity
- Time
  - Prior interventions or treatments including medications
  - Secondary complaints
Family History

- Family History – specific health related events in the patient’s family. Includes information about the health status or cause of death of parents, siblings, and children and the following diseases:
  - Orthopedic (arthritis (RA), scoliosis)
  - Neurologic (MS)
  - Pathology (heart disease, cancer, diabetes)

The BIG FIVE

What are the Big 5 hereditary diseases to ask a patient about their family history?

- Orthopedic (arthritis (RA), scoliosis)
- Neurologic (MS)
- Pathology (heart disease, cancer, diabetes)

The Consultation

- Past Health history
  - Type, date, treatment, current status
- Prior Illness
  - Type, date, treatment, outcome
- Prior Surgery
  - Type, date, reason, results, current status

Complicating or Co-Morbidity Factors

A Multiplier for # of Visits

Patient Characteristics

- Older age
- Pregnancy
- Psychosocial factors
- Delay treatment > 7 days
- Non-compliance
- Lifestyle habits
- Obesity
- Type of work activities


Injury Characteristics

- Severe initial injury
- > 3 previous episodes
- Severe signs and symptoms
- Number/severity of previous exacerbations
- Treatment withdrawal fails to sustain MTI (maximum tolerable intensity)
- (Establish support for long term care)
Complicating Factors

**History**
- Pre-existing pathology/surgery
- History of lost time
- History of prior treatment
- Congenital anomalies
- Symptoms persist despite previous treatment

**Complicating factors that may document the necessity of ongoing care for chronic conditions.**
- Severity of symptoms and objective findings
- Patient compliance and/or non-compliance factors
- Factors related to age
- Severity of initial mechanism of injury
- Number of previous injuries (NI episodes)
- Number and/or severity of exacerbations
- Psycho-social factors (pre-existing or arising during care)
- Pre-existing pathology or surgical alteration
- Waiting >7 days before seeking some form of treatment
- Ongoing symptoms despite prior treatment
- Nature of employment / work activities or ergonomics
- History of lost time
- History of prior treatment
- Lifestyle habits
- Congenital anomalies
- Treatment withdrawal fails to sustain MTB (Maximum therapeutic Benefit)

The Consultation

**Social History**
- Marital status
- Employment history
- Occupational history
- Use of drugs, alcohol, tobacco
- Level of education
- Sexual history and social factors

**Physical exam**
- Clearly document treatment given on day of visit
- What was adjusted
- Each region treated, list primary/secondary
- Primary diagnosis must be subluxation – Cervical, Thoracic, Lumbar, Sacral or Pelvic
- Secondary diagnosis(es)

Treatment Plans

**Treatment plan**
- Initial treatment date
- Therapeutic modalities – education/exercise training
- Level of care recommended
- Visit duration/frequency
- Specific measurable goals achieved with treatment
- Objective measures to evaluate treatment effectiveness

**Elements of a Treatment Plan**

1. Recommended level of care (duration and frequency of visits)
2. Specific treatment goals
3. Objective measures to evaluate treatment effectiveness

**KEEP IN MIND…**
- Your unique perspective makes a difference
- If the guidelines say 2 times a week, but you feel they should be seen 4 times, then please use your individual clinical expertise.
From a recently received denial letter

necessary. The necessity of continued care is dependent upon objective evidence of improvement. The records supplied do not contain patient specific objective examination findings that demonstrate ongoing functional gains. Due to the lack of continued ongoing objective gains, the care in question is not supported as being medically necessary.

What is a Treatment Plan?

According to Medicare

“A care plan is an ordered assembly of expected or planned activities, including observation goals, services, appointments and procedures, usually organized in phases or sessions, which have an objective of organizing and managing health care activity for the patient.”

What is a Treatment Plan?

1. A list of each complaint, with its relevant diagnoses
2. Treatments and modalities selected
3. Duration and frequency of care
4. Treatment goals
5. Objective measures to show progress

Weak Care Plans

- Only address frequency and duration of visits
- Neglect goals entirely
- Include goals, but
  - They are only subjective
  - They do not address function
  - They are not measurable

Weak Care Plans

Goals

Goals should be measurable, such as:
- VAS, ADLs, OATs, ROM

Goals should be specific, such as:
- Increase ability to stand without pain to thirty minutes by 5/17/2016.
- Change ADL by this much by this date
- Improve OAT score 50% by 6/22/2016
- Unspecific goals would be “increase ROM and decrease pain”

Short Term Goals:
The following are the short term goals I have outlined for treatment plan: reduce VAS to within 10 range of mobility, restore normal vertebral segmental motion and increase ability to move the affected area.

Short term goals restated:
1. Reduce pain
2. Increase pain-free ROM
3. Restore normal vertebral segmental motion
4. Increase ability to move affected area

Short term goals improved:
1. Reduce VAS from 8/10 to 5/10 within 2 weeks
2. Increase pain-free ROM by 50% within 2 weeks
3. If you restore normal vertebral segmental motion, you can’t adjust anymore, right?
4. Same as number 2?

Short term focus on symptoms and save function for long term.
Two weeks later

Assessment should discuss progress towards goals
- Were goals achieved?
- If not, why?
- Patient went on vacation
- Patient fell down the stairs
- How will the care plan change to adapt to goals that were not met?
  - Easier or harder exercises?
  - More or fewer visits?
  - Referral or new diagnostic test?

Short term goals restated:
1. Reduce pain by 10%
2. Increase strength (is there documented loss of strength?)
3. Increase endurance (how do you measure this?)
4. Increase ability to move affected area (measurable?)
5. Increase ability to exert force to affected area
AND (these are better)
1. Get 5-6 hours of quality sleep (within what time frame?)
2. Stand for more than 20 minutes (is this from Oswestry?)
3. Sit for more than 20 minutes pain free
4. Walk for more than 1 block pain free

Long term goals restated:
1. Increase ROM to pre-injury status (two weeks sooner than old LT goal?)
2. Restore health and function to pre-injury status (OATs)
3. Promote soft tissue healing (measure?)
4. Restore maximal strength and stability to joint (was strength/stability lost?)
5. Transition to HEP (two weeks sooner than last time this goal was established?)

Two weeks later

Long term goals:
My long term goals for [patient] are: increase range of motion to pre-injury status, restore health & function to pre-injury status, promote soft tissue healing, restore maximal strength and stability to joint and transition to home based exercise program.

Long term goals restated:
1. Increase ROM to pre-injury status (two weeks sooner than old LT goal?)
2. Restore health and function to pre-injury status (OATs)
3. Promote soft tissue healing (measurable?)
4. Restore maximal strength and stability to joint (was strength/stability lost?)
5. Transition to HEP (two weeks sooner than last time this goal was established?)

Treatment Plan
- Treatment Frequency and duration
- Treatment Goals
  - Short term Goals
    - To decrease pain, spasms and edema
    - Resolution of any radicular pain in the lower extremity
    - Low back pain consistently less than or equal to 6/10 with all activities
    - Resting low back pain with less than or equal to 2/10
    - Independent with basic self-care ADL without increased low back pain
  - Long-term Goals
    - Address their ADL
    - Low back pain at worst less than or equal to 4/10 with all activities
    - Patient will ambulate 15 minutes at 2.0 miles per hour without increased low back pain
    - Bilateral hip flexion, multifidus and gluteal strength to 4+ to 5/5
    - Independent self-management
    - To prepare the patient for a home-based exercise program
Care Plan
Example:
- At the acute stage: manipulation, EMS (unattended), ice, pulsed ultrasound and patient education as indicated
- In the sub-acute stage: manipulation-per-palpation, skilled therapeutic rehabilitation exercises to improve functional capacity, strength and endurance and to decrease pain with AIDs and patient education as indicated

Using OATs

Outcome Assessment Tools

“Outcomes in clinical practice provide the mechanism by which the health care provider, the patient, the public, and the payer are able to assess the end results of care and its effect upon the health of the patient and society.”

Outcome Assessment Tools
- Support medical necessity by quantifying patient functional loss.
- They “objectify the subjective”
- They measure a change in health status after exposure to a health care delivery system.

Goals

Outcome Assessment Tools

Neck Disability Index (NDI)
Modified Oswestry Low Back Disability Index

- Ten questions, six responses scored on an ascending scale (0, 1, 2, 3, 4, 5), total is divided by # of points possible
- Higher percentage = worse disability
- Administer at intake and every 6-12 visits, or 2-4 weeks

NDI scoring
- 0-4 points (0-4%) no disability
- 5-14 points (10-28%) mild disability
- 15-24 points (30-48%) moderate disability
- 25-34 points (50-64%) severe disability
- 35-50 points (70-100%) complete disability

Oswestry scoring

- 0% to 20% minimal disability
- 21% to 40% moderate disability
- 41% to 60% severe disability
- 50% to 60% crippled

i.e. 34% on NDI could be documented as “moderate functional deficiency”
Goals

OATs should be administered every 30 days, or as indicated
• 10% improvement = minimum detectable change
• 30% improvement = meaningful change
• 50% improvement = substantial change

OATs Inspired Goals

 Goals need to be measurable and specific
• Change ADL by this much by this date

“Enable patient to lift heavy weights without pain by 5/1/2016.”
  - from NDI, section 3

“Improve ability to stand without pain from 30 minutes to one hour by 5/20/2016.”
  - from Oswestry, section 6

Goals

Outcome Assessment Tools

The questionnaire that the patient completes during the re-exam now looks like this:

Prognosis

1. Excellent – full symptomatic and functional recovery expected within 2-4 weeks
2. Good - Symptomatic and functional recovery is expected in approximately 4-8 weeks but the patient may experience intermittent mild pain and some restriction of motion
3. Fair - The patient can expect to have a reduction of their symptom although some persistent pain and stiffness from the injury is expected and may require ongoing rehabilitation.
4. Poor - The nature of the patient’s injury and preexisting conditions bring into doubt the likelihood of full recovery. It is expected that patient will continue to experience intermittent to occasional paresthesias along with occasional to frequent pain and stiffness, necessitating palliative care.
5. **Guarded** - The patient’s condition is not expected to improve in the near future. They may expect to have continued muscle weakness and sensory deficit. Palliative and/or supportive care will be warranted for symptomatic relief and some improvement of function.

6. **Unstable** - Patient has not responded to the treatment trial and demonstrates evidence of deterioration. The likelihood of recovery with conservative care does not appear promising at this time. Surgical consult would be advisable.

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**Goals**

Plan of care should include recommendations for ongoing amelioration of musculoskeletal complaints, such as:
- Home program, lifestyle modifications, etc
- Introduce as soon as possible, reinforce, and document in the medical record.

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**Elements of a Treatment Plan**

1. Recommended level of care (duration and frequency of visits)
2. Specific treatment goals
3. Objective measures to evaluate treatment effectiveness

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**SOAP**

- Subjective
- Objective
- Assessment
- Plan

- Only 1/6 of a Problem Oriented Medical Record (POMR)

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**SOAP man**

Medicare Subsequent (Daily) Visits SOAP

- Subjective
  - Review of chief complaint(s) (is this in relationship to the initial visit or treatment for the exacerbation?)
  - Changes since last visit
  - Progress towards goals
  - System review if relevant
  - Response to last treatment?
  - Changes in symptoms?
  - Pain scale changes?
  - ADL performance?
  - Railroad Medicare: Address Function!
Objective

- Exam of area of the spine involved in Dx...
- Assessment of change in patient condition since last visit
- Evaluation of treatment effectiveness
- Subsequent visits
- Physical exam findings
- Neuro/ortho tests +/-
- Inspection, palpation
- Outcomes Assessment retest

Assessment

- Current diagnosis
- Patient response to treatment
- Compliance
- Changes to short and long term goals
Example Assessment

- Minor reinjury; Lumbago with sciatica, left side with sprain of the lumbar and lumbosacral regions
- dorsalgia with associated myalgia, with associated cervicalgia
data dysfunction on the cervical thoracic lumbar and sacral spine, complicated by morbid obesity and Type 2 diabetes mellitus with other specified complication
- M54.42 lumbago, sciatica of the left
- S33.5XXA sprain of the ligaments of the lumbar spine
- S33.6XXA sprain of the sacroiliac joint, initial encounter
- M54.2 Cervicalgia
- M79.1 Myalgia
- M99.01 Somatic and segmental dysfunction of the cervical spine
- M99.02 Somatic and segmental dysfunction of the thoracic spine
- M99.03 Somatic and segmental dysfunction of the lumbar spine
- M99.04 Somatic and segmental dysfunction of the sacrum spine
- E11.41 Type 2 diabetes mellitus with other specified complication

Based upon the patient’s complaints and physical findings it is my clinical opinion that conservative physical medicine health-care (treatment) for the current condition is medically necessary. Therefore continuation of manual manipulative therapy would be necessary.

No Longer use...

- Valid for 1 Visit
- Cervicalgia
- Dorsalgia
- Lumbalgia

Diagnosis Code Hierarchy

- Neurological
- Structural
- Functional
- Subluxation
- Pain
- Co-morbidities
- External causes

Diagnosis Code Hierarchy

- Neurological
  - M56.1 Postlaminectomy syndrome, not elsewhere classified
  - Postlaminectomy syndrome (need MRI/Ct/Xray)
  - Disc Displacement (need MRI/Ct to Confirm)
  - Neuromuscular
- Structural
  - DDD (need MRI/Ct/Xray)
  - Spinal Stenosis (MRI)
  - Scoliosis

Diagnosis Code Hierarchy

- Functional
  - Spinal (Worse than Strain)
  - Stiffness
- Soft Tissue
  - Myositis
  - Fibromyalgia
A sprain is a stretching or tearing of ligaments — the tough bands of fibrous tissue that connect two bones together in your joints. The most common location for a sprain is in your ankle.

A strain is a stretching or tearing of muscle or tendon.

### Pain
- Cervicalgia
- Dorsalgia
- Lumbalgia

### Co-morbidities/Compiling Factors
- Obese
- Diabetic
- Non Compliance
- Age
- High Blood Pressure

### External causes

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Even if diagnosis is the same as last visit, document each time.

Word “same” is not acceptable.

If diagnosis changes from prior visit:

- Explain if it relates to past history and how.

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**Ash your self?**

- Is new diagnosis due to a new injury?
  - If so, add Initial Treatment Date (ITD) to Item 14.

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**SOAP**

**Plan**

- Evaluation of treatment effectiveness
- In regards to the recommended level of care, duration, frequency and goals that were developed at the initial visit or at the time of exacerbation.
- Procedures performed
- Home instructions
- Changes to plan
- Next visit date

---

The Five Regions of the Spine are:

- Cervical region, C1 to C7, including the atlanto-occipital joint
- Thoracic, T1 through T12, including the costovertebral and costotransverse junctions
- Lumbar region, L1 through L5
- Sacral region the sacrum, including the sacrococcygeal joint
- Pelvic region, the sacroiliac joint and other pelvic articulations
Your unique prospective makes a difference

- If the guidelines say 3 times a week, but you feel they should be seen 4 times, then please use your individual clinical expertise.

Discharge when no further progress (ABN)

Re-Examination

- Formal re-examination should be done “to determine progress and need for further care”
- Should be done every 10-15 visits or every 30-45 days. RECOMMENDED EVERY 30 DAYS
- Recheck all positive findings and significant negative findings.

Medicare Guidelines for Re-evaluations

- Demonstrate the patients’ progress in objective, rather than conclusory terms
- The evaluation elements, noted in the initial evaluation need not be documented at each treatment; however, they must be present often enough to show measurable progress, or failure to progress
- A re-examination should include:
  - A brief consultation about current condition
  - Repeat of significant orthopedic and neurologic tests
  - Visual Analog Scale or Borg Scale
  - Outcome measures test repeated

Charging Fees for Medical Record Requests

- Another Great Member Benefit!
Two Bodies of Law

Medical record copy fees are governed by TWO bodies of law:

1. Wis. Stat. s. 146.83 – permits set fees depending on number of pages, as well as certification and retrieval fees.

2. HIPAA (45 CFR s. 164.524) – allows a reasonable, cost-based fee.

HIPAA only applies to “Covered Entities”.

Have a Question?

Call the WCA Help Desk
If NOT Subject to HIPAA

Follow Wisconsin law on medical record fees:

Provider Subject to HIPAA

Does State fee list or HIPAA “reasonable, cost-based fee” apply?

Depends on who is requesting the records and which fee is lower

Request from Patient

Because of the HIPAA “more stringent” rule, the law that provides the patient greater access or more privacy protection applies.

Lower fees to access records provides patient with greater access

Which law provides the lower fee, HIPAA or Wisconsin?

HIPAA permits providers to charge patients a “reasonable, cost-based fee” in the format requested (paper or electronic).

These fees are limited to actual or average costs relating to:

- Labor for copying
- Portable media supply costs
- Postage
- If patient agrees in advance, costs relating to preparing an explanation or summary of the protected health information (PHI).

May NOT include costs associated with verification, documentation, searching for and retrieving the PHI, maintaining systems, recouping capital for data access, storage or infrastructure, or other costs not listed above, even if such costs are authorized by State law.

Request from Patient

According to federal Office of Civil Rights (OCR), if patient requests records in electronic format and provider does not want to calculate the actual or average costs of labor or portable media supply cost, provider may charge patient $6.50.

If the patient requests records in paper format, the provider must determine whether the state per-page copy fee vs. the HIPAA reasonable, cost-based fee is lower. Provider should charge the patient the lower of the two fees.

This assumes that the per-page copy fee covers only the cost of labor, postage and portable media supply cost. Providers may not charge patients costs relating to equipment or system costs.
Request from Patient

- Treat record requests from third parties, such as a patient’s attorney, the same as you would a request from a patient ONLY if:
  - The patient initiates the request and directs you in writing to provide the records to the third party.
  - If it is not clear whether patient initiated the request, contact the patient and confirm.

Request from Patient’s PR

- Who is a Personal Representative?
  - Parent
  - Legal Guardian
  - Healthcare Power of Attorney

HIPAA or State law?

- Same analysis as if request came directly from patient
- Whichever fee (state or federal) is lower.

Request from Third Party Directly

- Request not initiated by patient
- Before releasing records to third party, obtain patient’s HIPAA authorization/informed consent
- Charge Wisconsin rates (including certification and retrieval fees)

Questions and Answers

- HIPAA Compliance
  - HIPAA Compliance
    - HIPAA requires covered entities to have contingency plans that establish policies and procedures regarding protected health information
    - HIPAA also administered by HHS
  - Office of Civil Rights

HIPAA Compliance

- HIPAA Compliance
  - HIPAA Compliance relates to fraud and abuse
  - Documentation, coding, billing and patient financial inconsistencies
  - Medical necessity and erroneous payment demands
  - Federal programs with extension through Office of Audit Services
Seven Elements of Our Compliance Program

- 1. Designate a compliance officer;
- 2. Conduct comprehensive training and education;
- 3. Implement written policies and procedures;
- 4. Conduct auditing and internal monitoring;
- 5. Develop accessible lines of communication;
- 6. Enforcing standards through well publicized disciplinary guidelines; and
- 7. Responding promptly to detected offenses and undertaking corrective actions.

DID you Know...

According the research #1 person to turn you in form non compliance?

Your Staff  Or  Your Spouse

Fraud, Waste and Abuse (FWA)

Fraud

- Obtaining services through misrepresentation
- Acting with Reckless Disregard, Deliberate Ignorance or intentional deception to deceive
- Concealment of material facts
- Healthcare providers and beneficiaries can be accountable in fraud investigations

Definition of Fraud

Example of Fraud

- Providing medically unnecessary services
- Falsifying certificates of medical necessity and technical requirements
- Billing for services that were never rendered
- Billing for services without supportive documentation and technical requirements
- Beneficiaries sharing ID cards and falsifying identity
- Knowingly reporting inaccurate claims
- Misrepresentation to join Medicare plans.

Definition of Waste

- Over-utilization of services
- Misuse of resources
- Medical Errors
- Money spent on preventable conditions
- Not caused by criminally negligent actions
- Generally occurs in conjunction with Fraud and/or Abuse

Examples of Waste

- Improper payment to providers contributing to overpayment
- Can occur when mis-representing who rendered therapy services
- Includes all actions within Fraud and Abuse
### Definition of Abuse

**Abuse**
- Occurs more commonly than fraud
- Typically not a direct result of fraudulent activity
- Practices that do not meet professionally recognized standards, are medically unnecessary, and are not fairly priced.

### Examples of Abuse
- Providing medically unnecessary services
- Routinely providing services above expected clinical standards
- Over-utilization of particular billing codes without meeting the technical requirements
- Lack of documentation to support direct codes billed

### Fraud and Abuse

**Fraud**
- When someone intentionally deceives or makes misrepresentations to obtain money or property of any health care benefit program

**Abuse**
- When health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program

The primary difference between fraud and abuse is intention.

### Why Train on FWA?
- Compliance is EVERYONE’s responsibility!
- FWA training is an integral part of an organizations Compliance Program
- FWA training educates staff on processes for reporting suspected FWA without retaliation
- FWA training informs staff of disciplinary guidelines for non-compliance or fraudulent behavior.

### Who commits fraud?

- CMS recognizes that most healthcare professionals are honest, trustworthy, and responsible.
- However, anyone can commit fraud
  - Health Care Agencies
  - Health Care Insurers
  - Health care providers and suppliers
  - Non-Clinical Support Staff
  - Business owners
  - Medicare and Medicaid Beneficiaries
  - Criminals

### Who is Responsible to prevent, detect and report FWA?

- CMS and Health Insurance Agencies
- CMS and Health Insurance Agency staff
- Healthcare providers, including non-clinical support staff
- State and Federal Agencies
- Beneficiaries
- YOU!
Who is Auditing?

- CMS
- Medicare Contractors
- OIG
- DOJ
- FBI
- State Attorney Generals
- State Licensing Boards
- Commercial Insurance Carriers

How is CMS Auditing for FWA?

- Affordable Care Act (ACA) was expanded
  1. More rigorous screening
  2. Termination from Federal Programs/Exclusions
  3. May temporarily stop enrollments in high-risk areas
  4. Can temporarily stop payments in cases of suspected fraud
- CMS uses Automated Claims Screening and Predictive Analytics software to establish "outlier claims/codes"
- Potential FWA are shared with all Federally programs: (CMS, Medicaid, VA, Indian Health, SSA, Disability Administration, and DOJ)
- CMS is working more closely with the DOJ, OIG, HHS, FBI, AGO, and Local/State Law Enforcement Agencies
- Increased denial of claims based on data mining aberrances, for example increased use of 97112.

Laws Referenced during FWA investigations

- False Claims Act (FCA) 1863
- American Recovery and Reinvestment Act 2009
- Anti-Kickback Statute
- Beneficiary Inducement Statute
- Self-Referral Prohibition Statute (Stark Law)
- Red Flag Rule (Identity Theft Protection)
- Health Information Portability and Accountability Act (HIPAA)
- Excluded Entities and Individuals
- Civil Monetary Penalties

What occurs if FWA is detected?

- When fraud is detected and confirmed enforcement actions include:
  - All payments are suspended
  - Claims are denied pending pre-payment review
  - Billing privileges and exclusions applied
  - Referral to Law Enforcement while establishing Civil monetary penalties, fines and arrests are determined
  - Repayment amounts are determined

What are CMS’ Targeted Strategies to Combat FWA?

- Increased use of technology to detect FWA patterns?
- Establishment of Health Care Fraud Prevention and Enforcement Action Teams (HEAT) and Strike Force Teams
- Increases in the RAC Auditing Programs (Federal and State Level requirements)
- Zone Program Integrity Contractors (ZPIC)
- Providing training to beneficiaries to detect and report FWA

Strike Force Teams

- Strike Force Teams
- Fraud “Hot Spot” locations
- Use advanced data analysis to identify high-billing levels in health care fraud hot spots
- Identify potential fraud cases
- Partner with HEAT teams
- CMS suspends payments
  - In conjunction with Fraud Strike Force arrests
Health Care Fraud Prevention and Enforcement Action (HEAT) Team

- Joint initiative between Department of Health and Human Services and Department of Justice
- Improve inter-agency collaboration on reducing and preventing fraud in Federal health care programs
- Increase coordination, data sharing, and training among investigators, agents, prosecutors, analysts, and policymakers
- Expanded to 29 Fraud Strike Force cities

Joint Initiative between Department of Health and Human Services and Department of Justice

Improve inter-agency collaboration on reducing and preventing fraud in Federal health care programs

In October 2016 Fraud Strike Force operations

- Led to charges against 91 people including doctors, nurses and other professionals
- $532 million in false billing (fraud)
- $108 million in wrongfully denied coverage
- $90 million in medically unnecessary care
- $100 million in community mental health care
- Expanded to 29 Fraud Strike Force cities

Here are some ways you can protect yourself from fraud

- Record appointments and services
- Review services provided
- Compare services actually received with services on your Medicare Summary Notice
- Report suspected fraud
- Remember to protect personal information, such as your Medicare card and bank account numbers

Zone Program Integrity Contractors (ZPIC)

- The ZPIC’s main responsibilities are to:
  - Investigate leads generated by the new Fraud Prevention System (FPS) and a variety of other sources
  - Analyze suspected FWA, proposes administrative actions to CMS, and provides feedback to CMS on the FPS
  - Makes Law Enforcement Recommendations while supporting the legal investigation
  - Identifies recovery dollar amounts based on findings

Zone Program Integrity Contractors (ZPIC)

ZPIC Map

Medicare Fraud & Abuse Resource Guide

Resources

Medicare Products

“4Rs” for Fighting Medicare Fraud

Here are some ways you can protect yourself from fraud

- Record appointments and services
- Review services provided
- Compare services actually received with services on your Medicare Summary Notice
- Report suspected fraud
- Remember to protect personal information, such as your Medicare card and bank account numbers
### Resources

<table>
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<th>Centers for Medicare &amp; Medicaid Services (CMS)</th>
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<td>MyMedicare.gov</td>
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<tr>
<td>Medicare.gov/fraud</td>
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<tr>
<td>Social Security</td>
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<tr>
<td>1-800-772-1213</td>
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<tr>
<td>TTY users should call 1-800-325-0778</td>
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<td>SSA.gov</td>
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<td>Senior Medicare Patrol Program</td>
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<td>SMPResource.org</td>
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<td>National Health Care Anti-Fraud Association</td>
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<td>NHCAA.org</td>
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<tr>
<td>NBI Medic’s Parts C&amp;D Fraud Reporting Group</td>
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<tr>
<td>1-877-7SafeRx (1-877-772-3379)</td>
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<tr>
<td>healthintegrity.org/contracts/nbi-medica/reporting</td>
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<tr>
<td>NBI MEDIC at 1-877-7SafeRx (1-877-722-3379)</td>
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<tr>
<td>CMS Outreach &amp; Education</td>
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<tr>
<td>medic-outreach.rainmakersolutions.com/</td>
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<td>2015 HCFAC Report</td>
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<tr>
<td>OIG.hhs.gov/publications/docs/hcfac/FY2015-hcfac.pdf</td>
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<tr>
<td>Medicaid Beneficiary Education</td>
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<tr>
<td>CMS.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html</td>
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<td>Prevention Toolkit</td>
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<td>CMS.gov/outreach-and-education/outreach/partnerships/fraudpreventiontoolkit</td>
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<td>CMS Program Integrity</td>
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<td>CMS.gov/About-CMS/Components/CPI/Center-for-program-integrity.html</td>
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<td>Fraud Hotline</td>
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<tr>
<td>1-800-HHS-TIPS (1-800-447-8477)</td>
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<tr>
<td>TTY 1-800-337-4950</td>
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### Key Points to Remember

- The key difference between fraud and abuse is intention.
- Improper payments are often mistakes.
- CMS fights fraud and abuse with support from Program Integrity Contractors.
- You can fight fraud and abuse with the 4Rs: Record, Review, Report, Remember.
- There are many sources of additional information.

### Take steps to protect yourself

- The OIG is quite clear in several of its recommendations.
- It requires addressing risk areas through the development of written standards and procedures.
- The office also advises practices to create a resource manual containing their written standards and procedures as well as information, such as OIG fraud alerts and advisory opinions, in addition to CMS administrative directives and carrier bulletins.

- A lesser-known program is called “OIG compliance.” While there are no posted fines for not having an OIG compliance manual, having one is required by the Affordable Care Act if the office treats Medicare or Medicaid beneficiaries. Therefore, if an office is audited for one of these claims, not having an OIG compliance manual is classified as a violation.

- OIG compliance is quite different from HIPAA compliance, which has been in the news a lot lately. And HIPAA compliance is mandatory—you do have to fear the government fining you if you are audited randomly, investigated due to a patient complaint, or run afoul of the HIPAA laws for any other reason. Moreover, HIPAA actions have been on an unprecedented rise in 2016.
A mitigating factor in this determination has been the existence of an effective compliance program as defined in the Sentencing Guidelines. The health care industry has used the Sentencing Guidelines as a framework reference for establishing a compliance program and compliance guidance. Every clinic should develop and implement a Compliance Program. This is separate from HIPAA. It is required that all providers and personnel adhere to all components of the Program as it applies to their duties and responsibilities. The Compliance Program consists of seven foundational elements.

- Designate a compliance officer;
- Conduct comprehensive training and education;
- Implement written policies and procedures;
- Conduct auditing and internal monitoring;
- Develop accessible lines of communication;
- Enforcing standards through well-publicized disciplinary guidelines; and
- Responding promptly to detected offenses and undertaking corrective actions.

If you will, an eighth element has been added to make sure all employees and if applicable, members of the Board of Directors have been checked on the Exclusion Database List of the Office of Inspector General. https://exclusions.oig.hhs.gov/ Print and put in Compliance Manual.

The government believes that a compliance plan will prevent violations and offer to reduce the potential for liability should violations still occur.

- Prevents violations, but should they occur, it would be abuse
- Violations are built into the law if they have a compliance plan
- The compliance plan acts as a mechanism as a training tool.
- Promote a culture of ethical behavior
- Fulfills our legal duty to filing truthful claims
- Cost-effective
- Peace of mind to management
- Positive impact in the office, corporation and public image
- Simply good business practice

The Compliance Plan:
- To assure compliance with and conformity to all applicable federal and state laws and regulations governing the organization;
- A "LivingDocument"
- Must be an "effective" program
- A commitment
- Not a "one size fits all" program
- Must be reviewed at least annually
- The goal of every office should be to adhere to all applicable state and federal regulations, while providing quality, comprehensive health care.
Compliance and Medicare

- Patient Protection and Affordable Care Act (Public Law 111-148)
- Federal Register / Vol. 75, No. 184 / Thursday, September 23, 2010
- Must adopt a compliance plan as a condition of enrollment
- Patient care is first priority
- Speed and optimize proper payment of claims
- Minimize billing mistakes
- Help protect patient privacy
- Reduce the chance of an audit
- Avoid conflicts of interest
- Avoid anti-kickback and self-referral

Culpability score mitigation factors

- Upper level employee “participated in, condoned, or was willfully ignorant of the offense”
- If the organization reported the offense promptly
- If the organization cooperated with the government investigators
- If the organization accepted responsibility for the violation

Fraud and Abuse Laws

- Key fraud and abuse laws
  - False Claims Act
  - Anti-Kickback Statute
  - Ethics in Physician Referrals Act (“Stark”)
  - Civil Monetary Penalties Law
  - Idaho Statutes
  - Report and repayment obligations
  - Compliance programs

False Claims Act (18 USC 1347)

The Act, also known as the Lincoln Law, was created in 1863 under Abraham Lincoln’s administration, to expose fraud and profiteering during the Civil War.

- It allowed people to expose others who made a false claim against the government.
- The Act provided protection from retaliation actions such as job loss or other damages.
- In 1986, the Qui Tam Law was added, allowing private citizens to sue on behalf of the US government, keeping a percentage (usually 15-30%) of the recovered money for themselves.
False Claims Act
- Cannot knowingly submit a false claim for payment to the federal government.
- Waiving deductibles or co-payments and not reporting to carriers.
- Up-coding for higher reimbursements.
- Down-coding based on payer type.
- Submitting claims for medical services not provided.
- Even a mistake... Need to have measures in place for checks and balances every 30 days.
- Theses present "deliberate ignorance or reckless disregard of the truth related to the claim."
- Must report and repay any overpayment within 60 days.

Spencer Chiropractor to Pay $42,349 to Resolve False Claims Act Allegations
- Elizabeth Kressin, D.C., from Spencer, Iowa, has agreed to pay $42,349 to resolve allegations she violated the False Claims Act.
- Kressin caused the submission of improper claims from January 1, 2008, through June 30, 2015.
- The claims settled by the agreement are allegations only; there has been no admission or judicial determination of liability.

- Spencer Chiropractor to Pay $62,349 to Resolve False Claims Act Allegations
- Elizabeth Kressin, D.C., from Spencer, Iowa, has agreed to pay $62,349 to resolve allegations she violated the False Claims Act.
- Kressin caused the submission of improper claims from January 1, 2008, through June 30, 2015.
- The claims settled by the agreement are allegations only; there has been no admission or judicial determination of liability.

False Claims Act
- Penalties
  - Repayment plus interest
  - Civil monetary penalties of $5,500 to $11,000 per claim
  - 3x damages
  - Exclusion from Medicare/Medicaid/other insurance programs (18 USC 1347)

False Claims Act: Examples
- Claims for services that were not provided or were different than claimed.
- Failure to comply with the quality of care.
- Provision of "worthless" care.
- Failure to comply with conditions of payment or relevant fraud and abuse laws.
- Express or implied certification of compliance when submit claims.

Did you know... Its name is an abbreviation of the Latin phrase "qui tam pro domino rege quam pro se ipso in hac parte sequitur," meaning "[he] who sues in this matter for the king as well as for himself."
Anti-Kickback Statute
(42 USC 1320a-7b; 42 CFR 1001.952)

- Cannot knowingly and willfully offer, pay, solicit or receive remuneration to induce referrals for items or services covered by government program unless transaction fits within a regulatory safe harbor.
  
  (42 USC 1320a-7b(b))
  
  - “One purpose test”
    - Anti-Kickback Statute applies if one purpose of the remuneration is to induce referrals even if there are other non-economic purposes.
    - (U.S. v. Greber, 760 F.2d 68 (3rd Cir. 1985)).
    - Difficult to disprove.
    - Ignorance of the law is no excuse.

- Penalties
  - 5 years in prison
  - $25,000 criminal fine
  - $50,000 penalty
  - 3x damages
  - Exclusion from Medicare/Medicaid

  (42 USC 1320a-7b(b); 42 CFR 1003.102)

- Anti-Kickback violation = False Claims Act violation
- Lower standard of proof
- Subject to False Claims Act penalties
- Subject to qui t'am suit.
  
  (42 USC 1320a-7a(a)(7))


Warning:

Anytime you want to:
- Give or receive anything to induce or reward referrals, or
- Do any deal with a referral source.

Thanks you Notes

Mrs. Smith,

Thank you for referring Robert Anderson to our practice. One of the finest compliments a practice can receive is the referral of friends and family. We appreciate your confidence, and we assure you that we will care for Robert's health needs as we would our own family members.

Please enjoy the enclosed gift card for a free appointment as our way of saying an extra-special “Thank you.”

I will not be able to see you any more as I violated numerous laws and can be in prison.
Who Wants to Pay a Million to Medicare?

Which of the following violates the Anti-Kickback Statute?

A. Paying a referring physician more than fair market value for medical director or other services?
B. Charging a referring physician less than fair market value to use your space or equipment?
C. Hiring a referring physician to act as a consultant even though you really do not need one?
D. Sending a “thank you” gift to referring providers or their offices?
E. All of the Above

Anti-Kickback Statute

- Applies to any form of remuneration to induce or reward referrals for federal program business.
- Money.
- Free or discounted items or services (e.g., perks, gifts, space, equipment, meals, insurance, trips, CME, etc.).
- Overpayments or underpayments (e.g., not fair market value).
- Payments for items or services that are not provided.
- Payments for items or services that are not necessary.
- Professional courtesies.
- Waivers of copays or deductibles.
- Low interest loans or subsidies.
- Business opportunities that are not commercially reasonable.
- Incentives that are only nominal in value are not prohibited by the Inducement Law.
- No more than $10 per item, or $50 in the aggregate on an annual basis.
- One free exam, x-ray or therapy is a risk.
- Anything else of value.

Are Your Spinal Screening Tests Legal?

Monday, December 12, 2016

Thanks for Coming here is your free Bio freeze, your tee-shirt and water bottle
The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. Where remuneration is paid purposefully to induce or reward referrals of items or services payable by a Federal health care program, the anti-kickback statute is violated.

The statute attributes criminal liability to both parties involved in the kickback arrangement.

For purposes of the anti-kickback statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

For enforcement purposes, the OIG has deemed that services cannot exceed $10 per item of service or $50 in the aggregate annually.

For any type of free care offered by a provider, however, regardless of whether it is preventive care as defined in the regulation, it is necessary to determine whether the free care promotes the provision of other, non-preventive care reimbursable by Medicare or Medicaid.

In this advisory opinion, the OIG based their opinion on whether providing the free service would induce a patient to obtain other services provided by that entity.

As an example, if the hospital makes appointments for individuals with one of its physicians, offers individuals discounts for additional covered services, or otherwise promotes its particular programs, an inference may be drawn that the free screening test was an inducement to choose the hospital as a provider of other services.

The screening tests would be permissible if the hospital provided an individual who tests positive for a chronic condition, with general information or literature and a recommendation that the individual contact his or her personal physician.

Before taking part in any marketing or screening activities, it is advised that the physician obtain legal advice before proceeding.

It is recommended that the policies pertaining to these screenings are well documented in a compliance manual.

The OIG recommends a compliance manual for policies pertaining to Federal and state programs.

This manual should not be confused with the HIPAA manual.

If called into question the presence of a Compliance Manual will be used as a mitigating factor against further sanctions and fines.
Did you Know...

- Ransomware has been the fastest growing type of cybercrime of the year. The FBI says cybercriminals could rake in almost $1 billion from these attacks in 2017 alone.
- Ransomware is quickly becoming the common cybercriminal’s favorite method of attack.
- That’s because it is easy to mass deploy, payoffs can be massive, and with the use of Bitcoin as currency, payment exchanges can be virtually anonymous.
- Big way to get infected…Facebook.

Wisconsin

- Anti-Kickback Statute: Safe Harbors
  - No liability if satisfy all the requirements of a safe harbor.
  - Not required to fit within safe harbor because the ultimate question is whether “one purpose” of remuneration is to induce or reward referrals.
  - The closer you come to satisfying regulatory requirements, the safer you will be.
Anti-Kickback Statute: Safe Harbors

- Exceptions and safe harbors
- Bona fide employment
- Personal services contracts
- Leases for space or equipment
- Investments in group practice
- Investments in ASCs
- Sale of practice
- Recruitment
- Certain investment interests
- Waiver of beneficiary coinsurance and deductible amounts.

(42 CFR 1001.952)

Anti-Kickback Statute: Safe Harbors (cont.)

- OB malpractice insurance subsidies
- Referral services
- Referral arrangements for specialty services
- Warranties
- Discounts
- Group purchasing organizations
- Price reductions offered to health plans and MCOs
- Ambulance replenishing
- Health centers
- Electronic health record items or services

(42 CFR 1001.952)

Anti-Kickback Statute

- No de minimus safe harbor.
  - But not too much risk if remuneration is negligible.
- No “fair market value” safe harbor.
  - “Fair market value” payment does not legitimize a payment if there is an illegal purpose. (70 FR 4864)
  - But fairly safe if remuneration represents fair market value for legitimate, needed services or items.
- Consider risk of federal program abuse.
  - Due to nature of transaction.
  - Incorporate safeguards to protect against abuse.

Advisory Opinions

- OIG may issue advisory opinions.
- Not binding on anyone other than participants to the opinion.
- But you are probably fairly safe if you act consistently with favorable advisory opinion.

Stark Law

- The Stark law is named after Rep. Fortney Hillman “Pete” Stark, Jr., who proposed the statute; it is not a description of the statute itself.
- The Stark law’s real name is the Ethics in Patient Referrals Act.
If a physician (or their family member) has a financial relationship with an entity:
- The physician may not refer patients to that entity for designated health services, and
- The entity may not bill for such designated health services unless an arrangement structured to fit within a regulatory exception. (42 CFR 411.353)

Physician cannot refer and DHS provider cannot bill for DHS unless transaction fits in safe harbor.

Stark law applies to referrals by a physician to entities with which the physician (or their family member) has a financial relationship.

- Physician =
  - MDs
  - DOs
  - Oral surgeons
  - Dentists
  - Podiatrists
  - Optometrists
  - Chiropractors
  (42 CFR 411.351)

- Family member =
  - Spouse
  - Parent, child
  - Sibling
  - Stepparent, stepchild, stepSibling
  - Grandparent, grandchild
  - In-law

Penalties:
- No payment for services provided per improper referral.
- Repayment of payments improperly received within 60 days.
- Civil penalties.
- $15,000 per claim submitted
- $100,000 per scheme
(42 CFR 411.353, 1001.102(a)(5), and 1001.103(b))
- May also constitute Anti-Kickback Statute violation
- May trigger False Claims Act.

Both the Stark law and the anti-kickback statute are federal laws and therefore only apply to programs such as Medicare, Medicaid, CHAMPUS, and other federal entitlement programs (FEPs).
- So, if you don’t participate in Medicare, Medicaid, or related government healthcare services, you’re not at risk of a violation.
- But, because almost every state has a law against self-referrals, you do need to worry about those regulations—you could think of them as mini-Stark laws—as they frequently track, in whole or in part, the federal Stark laws.
- Sometimes these laws are even stricter than the federal ones, so have your attorney advise you on the specifics of your state.
Even if your practice treats beneficiaries, you needn’t worry about the Stark law unless your practice provides one or more of the following 11 services referred to as designated health services or DHSs.

These include:
- clinical laboratory services;
- physical therapy services;
- occupational therapy services;
- radiology (including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services);
- radiation therapy services and supplies;
- durable medical equipment and supplies;
- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, prosthetic devices, and supplies;
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

It’s easy to confuse Stark law and the anti-kickback statute because they address similar issues, have similar safe harbors, and most problems arise under both laws because of improper referrals. But a violation of the Stark laws will cost you money; a violation of the anti-kickback statute can land you in jail (and cost you money, too).

The Stark law applies only to doctors and their immediate family members (if they are in a position to make referrals).

For example: If Mary Smith, DC (mother of John Smith, DC), refers one of her Medicare patients to her son’s practice for physical therapy, such a referral would violate the Stark law, as physical therapy is a Medicare-designated health service.

If, however, John Smith’s father, who is a lawyer, made such a referral, it would not be prohibited because he is not a doctor.

To clarify, the purpose of the Stark law is to prevent the referral of a patient for a designated health service to another entity in which the doctor (or the doctor’s close relative) has a financial interest.

A classic example is that of an MRI center:

John Smith, MD, owns shares in Acme MRI Center. He refers his Medicare patients to Acme for MRI services. As a result of his ownership interest, Smith will benefit financially from such referrals. Therefore, such referral is prohibited.

On the other hand, if Smith had his own MRI machine or if he was a member of a valid group practice that maintained its own machine, there would be no violation because he wouldn’t be receiving compensation from a third party.

Stark
- Cannot bill or receive payment for services for prohibited referrals during the “period of disallowance.”
  - Begins when financial relationship fails to satisfy one of the safe harbors.
  - Ends when:
    - Relationship brought into compliance, and
    - Amounts overpaid or underpaid are repaid.
- Prospective compliance alone does not end the period of noncompliance.

Stark
- Applies to referrals by physician to entities with which physician (or their family member) has financial relationship.
  - Direct relationship.
  - Indirect relationship (e.g., through ownership in another entity).
  - Financial relationship =
    - Ownership or investment: stocks, bonds, partnership, membership shares, secured loans, securities, etc.,
    - Compensation: employment, contract, lease, payments, gifts, free or discounted items, and virtually any other exchange of remuneration.
Stark

- Applies to referrals (orders, requests, plan of care, certification) by physician for DHS performed by others.
- Other providers or facilities.
- Others in physician’s own group.
- Other employees or contractors.
- Does not apply to services the physician personally performs.
- Physician may perform his own DHS.
- Recruit ancillary, technical, facility fees.
- Does not apply to many services performed by radiologists or pathologists since they usually do not make “referrals”.

(42 CFR 411.351)

Stark

- Stark does not require intent to violate statute.
- No “good faith” compliance.
- To comply with Stark, transaction must either:
  - Fall outside statute, i.e., no “financial relationship” or “referral”, or
  - Fit within regulatory safe harbor.
- Exception: Entity may bill for prohibited services rendered per improper referral if entity did not know and did not act in reckless disregard or deliberate indifference concerning the identity of the referring physician.

(42 CFR 411.353)

Stark: Safe Harbors

- Stark contains numerous safe harbors.
- Applicable to both ownership/investment and compensation arrangements.
- Applicable to only ownership/investment arrangements.
- Applicable to only compensation arrangements.
- No liability if comply with all the requirements of an applicable safe harbor.
- Need only comply with one safe harbor for each financial relationship.

(42 CFR 411.355-357)

Stark: Exceptions for Both Ownership and Compensation

- Physician services rendered by another physician in same group practice or under such physician’s supervision.
- In-office ancillary services provided through group practice*.
- Intra-family rural referrals.

(42 CFR 411.355)

* Must qualify as “group practice” under 42 CFR 411.352.

Stark: Exceptions for Only Compensation Arrangements

- Bona fide employment relationships.
- Personal services contracts.
- Office space or equipment rental.
- Physician recruitment.
- Physician retention.
- Remuneration unrelated to DHS.
- Fair market value.
- Non-monetary compensation up to $300.
- Medical staff incidental benefits.
- Compliance training.
- Community-wide health information system.
- Professional courtesy.
- Certain payments by a physician for items or services at FMV.
- Others.

(42 CFR 411.355-357)

Stark: Common Problems

- Physician referrals to entities that the physician owns.
- Compensation arrangements which pay physicians based on their referrals to others (e.g., “eat what you kill” for ancillary services).
- Paying physicians more than fair market value.
- Paying physicians even though services are not provided or needed.
- Giving physicians discounts or freebies (e.g., professional courtesies).
- Subsidizing physician practices.
- Financial arrangements without a written contract.
- Financial arrangements with a written contract.
- Performing after a written contract has expired.
- Amending contracts within one year.
- Leases that fail to satisfy lease safe harbors (e.g., “per click”, “on demand”, non-exclusive).

(42 CFR 411.355-357)
Many chiropractors, if not most, will not have to be concerned with the Stark law. But even if it doesn’t apply to you, consider the implementation of a compliance program, which might save you from problems in the future.

Civil Monetary Penalties Law
(42 USC 1320a-7a)

- Prohibits certain specified conduct:
  - Submitting false or fraudulent claims or misrepresenting facts relevant to services.
  - Offering, soliciting, giving or receiving remuneration to induce referrals (i.e., kickbacks).
  - Offering inducements to program beneficiaries.
  - Offering inducements to physicians to limit services.
  - Submitting claims for services ordered by, or contracting with, an excluded entity.
  - Failing to report and repay an overpayment.
  - Failing to grant govt timely access.

(42 USC 1320a-7a; 42 CFR 1003.102)

Inducements to Govt Program Patients

- Cannot offer or transfer money paid for work or a service to Medicare or state program beneficiaries.
  - If you know or should know that the payment is likely to influence the beneficiaries to order or receive items or services payable by federal or state programs from a particular provider.
- Penalty:
  - $10,000 for each item or service.
  - 3x amount claimed.
  - Repayment of amounts paid.
  - Exclusion from Medicare and Medicaid.

(42 USC 1320a-7(a)(5); 42 CFR 1003.102)

Penalties vary based on conduct, but generally range from:
- $2,000 to $50,000 fines
- 3x amount claimed
- Denial of payment
- Repayment of amounts improperly paid
- Exclusion from government programs

CMPL violations may also violate:
- False Claims Act
- Anti-Kickback Statute
- Stark
Inducements to Govt Program Patients

- "Remuneration" = anything of value, including but not limited to:
  - Waiver of co-pay and deductibles unless satisfy certain conditions, and
  - Items or services for free or less than fair market value unless satisfy certain conditions.

  - (42 USC 1320a-7a(i); 42 CFR 1003.101; OIG Bulletin, Gifts to Beneficiaries)

- "Remuneration" does not include:
  - Waivers or co-pays based on financial need or after failed collection efforts if certain conditions met.
  - Incentives to promote delivery of preventative care.
  - Payments meeting Anti-Kickback Statute safe harbor.
  - Retailer coupons, rebates or rewards offered to public.
  - Any other remuneration that promotes access to care and poses a low risk of harm to patients and federal health care programs.
  - Certain other situations.

  - (42 USC 1320a-7a(i); 42 CFR 1003.101)

- OIG has approved the following in opinions or comments:
  - Free or discounted item or service of low value, i.e.,
    - Each item or service is less than $10, and
    - Aggregate is less than $50 per patient per year.
  - Free screenings not conditioned on or tied to additional services from any provider. (Adv. Op. 09-11)

  - (Adv. Op. 09-11; OIG Bulletin, Offering Gifts and Inducements to Beneficiaries (8/02))

Pay $368,740.59 for allegedly violating the Civil Monetary Penalties Law.

- OIG alleged that:
  - Calvert submitted claims to Medicare, Medicaid and TRICARE for therapeutic services that required direct one-to-one patient contact when the Doctor was treating more than one patient at the same time.
  - Submitted claims to Medicare for patient re-evaluations when the Doctor was recertifying Medicare patients’ existing plans of care. OIG further alleged that Calvert improperly submitted claims to Medicare, Medicaid, and TRICARE for physical therapy services that failed to meet documentation requirements for time spent with patients and modalities used to treat patients.

Payment to Limit Services

- Hospital or CAH cannot knowingly make a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided to Medicare or Medicaid beneficiaries who are under the direct care of the physician.

- Includes “gainsharing” programs.

- Penalties:
  - $2000 for each individual with respect to whom payment made.
  - Any other penalty allowed by law.

  - (42 USC 1320a-7a(b)(1); 42 CFR 1003.102)

- UnityPoint at Home
  - UnityPoint, Iowa
  - Pay $18,562.95

  - For violating the Civil Monetary Penalties Law.

  - OIG alleged that UnityPoint employed an individual that it knew or should have known was excluded from participation in Federal health care programs.
Excluded Entities

- Cannot submit claim for item or service ordered or furnished by an excluded person.
- Cannot hire or contract with an excluded entity or arrange for excluded entity to provide items or services payable by federal programs.
- Penalties
  - $10,000 per item or service.
  - 3x amount claimed.
  - Repayment of amounts paid.
  - Exclusion from Medicare and Medicaid

(42 USC 1320a-7(a)(8); 42 CFR 1003.102; OIG Bulletin, Effect of Exclusion)

Knowledge =
- Knew or should have known of exclusion.
- Notified by HHS of exclusion, e.g., in response to claim.
- Listed on the List of Excluded Individuals or Entities ("LEIE").

List of Excluded Individuals and Entities ("LEIE")

- OIG maintains LEIE and updates monthly: https://oig.hhs.gov/exclusions/exclusions_list.asp
- Check LEIE before hiring or contracting with entities.
  - Employees, contractors, vendors, medical staff, etc.
- Check LEIE periodically to determine status.
  - Employees, providers, vendors, medical staff members, ordering providers, and so forth
- Condition contracts and medical staff membership on non-exclusion.
- Respond promptly if receive notice of excluded entity.
OIG has the authority to exclude individuals and entities from Federally funded health care programs and maintains a list (List of Excluded Individuals and Entities (LEIE)) of all currently excluded individuals and entities. Anyone who hires an individual or entity on the LEIE may be subject to monetary penalties.

It’s as simple as 1…2…3:

- Go to http://exclusions.oig.hhs.gov/
- Click on Search for multiple individuals (See picture #2)
- Type in Staff's name
- If a name contains punctuation, you must include the punctuation in your search text. For example, if you are searching for the name “O’Connor,” you must include the apostrophe.
- An individual with a hyphenated name should be checked under each of the last names in the hyphenated name (e.g., Jane Smith-Jones should be checked under Jane Smith and Jane Jones, in addition to Jane Smith-Jones).

#3 Print off the Sheet and place it in your compliance manual

We have a gift for you

Repay Overpayments (18 USC 1347)
Repayment Law
- If provider has received an "overpayment", provider must:
  - Return the overpayment to federal agency, state, intermediary, or carrier, and
  - Notify the entity of the reason for the overpayment.
- Must report and repay within the later of:
  - 60 days after overpayment is identified, or
  - Date corresponding cost report is due.
  (42 USC 1320a-7k(d))
- No "finders keepers"

Repayment Law
- "Overpayment" = funds a person receives or retains to which the person, after applicable reconciliation, is not entitled, e.g.,
  - Payments for non-covered services
  - Payments in excess of the allowable amount
  - Errors and non-reimbursable expenses in cost reports
  - Duplicate payments
  - Receipt of Medicare payment when another payor is primary
  - Payments received in violation of:
    - Stark
    - Anti-Kickback Statute
    - Exclusion Statute

Repayment Law
- Condition of payment fromgovt program
  - Requires repayment, e.g.,
    - Billing or claim requirements
    - Anti-Kickback Statute
    - Stark
    - Civil Monetary Penalties re excluded individuals
- Condition of participation in govt program other regulation
  - Does not necessarily require repayment,
    - Conditions of Participation
    - Conditions of Coverage
    - Licensure requirements
    - HIPAA
    - EMTALA

Proposed Repayment Rule
- To report and repay overpayments, use existing voluntary refund process ("self-reported overpayment refund process") for contractor (Noridian).
  - Use form that contractor maintains on their website.
  - Among other things, must disclose:
    - How error was discovered
    - Corrective action plan to avoid repeat
    - Reason for refund
    - Total amount of refund
    - If statistical sample used, method for calculation.
  (77 FR 9179 (2/16/12))

Proposed Repayment Rule
- Must report and return payment within later of:
  - 60 days after overpayment identified, or
  - If overpayment related to issue in cost report, date corresponding cost report is due.
- Overpayment "identified" if person:
  - Has actual knowledge of existence of overpayment, or
  - Acts in reckless disregard or deliberate ignorance.

  Not necessarily amount of repayment.
- If have notice of potential overpayment, must make "reasonable inquiry" with "all deliberate speed" to determine whether overpayment exists.
Proposed Repayment Rule

- Repayment per Repayment Rule does not resolve violations or penalties under other laws, e.g.,
  - Anti-Kickback Statute, Civil Monetary Penalties Law, or False Claims Act, which are resolved by OIG or DOJ.
  - Stark, which is resolved by CMS.
- If Medicare contractor believes repayment involves violation of federal law, contractor may report repayment to the OIG, CMS, or other federal agency.
- Be careful how and what you disclose.
- May want to consider other disclosure protocols.
- OIG Self-Disclosure Protocol

Better to comply in the first place!

An Ounce of Prevention is Worth a Pound of Cure
- Benjamin Franklin

Create your own...

Seven Elements of Our Compliance Program

1. Designate a compliance officer;
2. Conduct comprehensive training and education;
3. Implement written policies and procedures;
4. Conduct auditing and internal monitoring;
5. Develop accessible lines of communication;
6. Enforcing standards through well publicized disciplinary guidelines;
7. Responding promptly to detected offenses and undertaking corrective actions;
8. Check the OIG Exclusion List

Step One: The OIG Compliance Officer

- Compliance Officer
- Compliance Professional
- Compliance Committee
- Compliance Consultant

Source Possibilities

- "To carry out such operational responsibility, such individuals shall be given adequate resources, appropriate authority, and direct access to the governing body of the entity," Federal Sentencing Guidelines.

COMPLIANCE COMMITTEE

- PURPOSE:
  - A Compliance Committee is established to ensure a comprehensive Compliance Program is designed, developed, implemented and continually monitored to ensure adherence with all applicable laws, statutes and regulations associated with the delivery of healthcare in a clinical environment.
Committee Members Are:
1. CEO, Physician: Dr Robert Anderson
2. Director of Clinical Operations, VP, Physician: Dr Christopher Anderson
3. Patient Benefits Specialist: Lauren Marx
4. Clinic Supervisor: Nichole Frederick
5. Personnel and Human Resources Director: Edna Anderson
6. Healthcare Consultant: Dr Evan Gwilliam

Responsibilities:
The Compliance Committee is responsible for:
1. The design, development and monitoring of a Compliance Program in accordance with the Code of Conduct and the Compliance Program Elements.
2. Preparation of an annual budget for compliance program activities.
3. Review and monitoring of all compliance-related allegations to ensure appropriate actions were taken for immediate resolution.
4. Reporting monthly reports to the Board of Directors on Committee activities.
5. Present policies and procedures to the Board of Directors for approval prior to implementation.
6. Continuously develop methods to improve the Compliance Program.
7. Hosting the annual medical record audit and educational programs for providers and personnel.
8. Review all policies and procedures of the Compliance Program on an annual basis.
9. Other duties and responsibilities as assigned.

Procedure:
Prior to the Compliance Committee meeting, a notice will be scheduled within the thirty days of the effective date of this Policy. Meetings will be held on a monthly basis or as deemed necessary.

Communication
Purpose:
A Communication Policy will empower providers, personnel and patients to anonymously present complaints regarding alleged non-compliant behavior or conduct allowing prompt investigation and immediate resolution.

Policy:
The Compliance Officer will maintain:
1. An ‘open door’ policy for all providers, personnel and patients to discuss compliance-related issues.
2. A Compliance Bulletin Board strategically located within the practice site.
3. A telephone hotline for anonymous reporting of alleged fraudulent or erroneous conduct.

Procedure:
A notice is posted on the Compliance Bulletin Board reminding patients, providers and personnel that they can discuss compliance related issues with the Compliance Officer at all times.
Compliance related information with subject matter materials are reviewed on a monthly basis to ensure accuracy of information posted.
Information will be posted to the Compliance Bulletin Board encouraging communication between providers, patients and practice personnel.
The Compliance Officer will monitor the telephone on a daily basis, documenting all calls. Response to allegations will be communicated within a timely manner to ensure the implementation of corrective action. The Compliance Officer will maintain all hotline activity documentation via a log book.

Step Two: Compliance Training and Education
Purpose:
A Compliance Training and Education program is a first line of defense for an organization.

Procedure:
Train new employees immediately and update as policies and procedures warrant.
Voluntary vs. Mandatory Training

- It has been a widely held assumption that adults want control of their learning experiences.
- One would assume by this that mandatory training would result in reduced motivation to learn and therefore reduced participation and transfer of training.
- Contrary to this belief, Baldwin, Magjuka & Loher (1990) found that the level of pre-training motivation increases when the training is perceived as mandatory and when the learner has an expectation of post-training accountability to management.

How Often?
Do you need education (3 total Hours)

- Minimum of 2 hours annually for basic Compliance training.
- Documentation Classes, Risk Management Classes, etc
- 1 hour of HIPAA Training
- The committee should continuously develop education that drills down to the physician and employee levels.

How Often?
Does your staff need Training

- Minimum of three hours annually.
- It should include information about how employees perform their jobs in compliance with practice standards, applicable regulations and the practice's commitment to an effective compliance program.

Sample Educational Topics:

- Medicare
- HIPAA
- Security
- Stark
- Red Flags
- False Claims
- Code of Conduct
- Red Flags
- Cost for Record Requests

Attestation
We Talked about:

- Date
- Time Started:
- Time Ended:
- Topics Discussed:
- Signature

1 copy in Compliance manual
1 copy in Staff file

Areas to Address in Compliance manual

- Record retention
- Self-disclosure
- Exclusion sanction checks
- Billing policies
- Unbundling
- Credit balance
- No charge visits
- Delegation of duties
- Documentation requirements.
How long do we keep records

Step Three: Policies and Procedures

Policies

- "The set of basic principles and associated guidelines, formulated and enforced by the governing body of an organization, to direct and limit its actions in pursuit of long-term goals." *Business Dictionary, Businessdictionary.com

Procedures

- "A fixed step-by-step sequence of activities or course of action...that must be followed in the same order to correctly perform a task.” *Business Dictionary

Policy and procedure statements should be placed in the Compliance Plan binder along with any forms and treatment guidelines.

- *OSHA COMPLIANCE Policy and Procedure:
- Hazardous Communications & Quality Assurance Policy and procedure
- EMERGENCY AND EVACUATION Plan Policy and Procedure:
- Schedule Policy and procedure
- WORK SCHEDULE Policy and Procedure:
- FLOOR PLAN – EVACUATION ROUTE Policy and Procedure:
- FISCAL Policy and Procedure: 
  Policy and procedure statements should be placed in the Compliance Plan binder along with any forms and treatment guidelines.

- INSURANCE VERIFICATION Policy and Procedure: Verification of patient insurance is extremely important. Insurance information is to be reviewed each time the patient presents. Accurate information will allow maximum reimbursement in a timely manner.
- PATIENT BILLING Policy and Procedure: Usually there are several policies associated with patient billing, however it will depend on the operations of the clinical site. Policies will have to identify the procedures performed by the site personnel to accomplish claims filing and patient billing functions.
- The Anderson Chiropractic Clinics expects patients to pay their outstanding balances in a timely manner. A bill for services is based on the patient’s Ability to Pay. A patient who refuses to pay their outstanding balance will be sent the patient to collections using the Credit Bureau Data, Inc. in La Crosse, Wi.
- Anderson Chiropractic Clinics accepts third-party coverage, but patients are expected to pay any remaining balance owed after the third-party coverage pays. Patients who do not have third-party coverage have the option to join ChiroHealth and pay for services as they are received.
- Collection Classifications & Debt Collection Policy and Procedure:
**PROFESSIONAL COURTESY Policy and Procedure:** Physicians cannot bill Medicare/Medicaid for treating their mothers, wives, close relatives or members of the physician’s household. Medicare also bars physicians from billing for their relatives’ care, under their partnerships’ or professional corporations’ provider number.

The following relationships fall under HCFA’s “immediate relatives” or “members of patient’s household” billing exclusion:
- Husband and wife
- Child
- Natural or adoptive parent, and natural sibling
- Adoptive sibling
- Grandparent and grandchild
- Spouse of grandparent and grandchild
- Step parent, biological, adoptive and stepcloser
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law

**WITNESSED PATIENT EXAMINATION Policy and Procedure:**
- Patient’s family; a roomer or boarder is not included
- Note: A “step” relationship or an “in-law” relationship continues, even if the marriage on which it is based ends in death or divorce
- Members of a patient’s household: those sharing a “common abode” with the patient as a part of a single family unit including those related by blood, marriage or adoption and domestic employees and personal care who lives with you as part of your family or who resides in a non-housekeeping

**GRIEVANCE Policy and Procedures:**
- Stepparent, stepsibling and stepsister
- Adoptive sibling
- Natural or adoptive parent, and natural sibling
- Natural or adoptive parent, and natural sibling

**INFECTION EXPOSURE CONTROL Plan Policy and Procedure:**
- Universal precautions shall be used to prevent contact with blood or other potentially infectious materials.
- Under circumstances where it is difficult or impossible to differentiate between body fluids, all body fluids shall be considered potentially infectious.

**EQUIPMENT INSPECTION Policy and Procedure:**
- Equipment used in the diagnosis and treatment of patients will be inspected and maintained on a regular basis to ensure the safety of patients and personnel. Testing and inspection of all biomedical equipment intended for use in the diagnosis and treatment of patients will be performed at least annually. Documentation of biomedical equipment and electrical safety inspections, equipment repairs and corrective actions will be maintained and updated when appropriate.

**POLICY TRAITE POLICY**

**MEDICAL RECORDS STANDARD Policy and Procedure**

**MEDICAL RECORD RETENTION Policy and Procedure**

**PATIENT IN-TAKE Policy and Procedure**

**GRIEVANCE Policy and Procedures**

**Quality Assurance Program Policy and Procedure:**

**POLICY TRIAGE POLICY**

**Density and Ancillary Testing Policy and Procedures**

Radiology services will be available to the patients of the Clinic in an effort to provide comprehensive healthcare services.

Basic radiological services will be provided under the direction of the Director of Radiology. Personnel will be appropriately licensed or trained to perform radiology services in a safe and timely manner. Services will be provided in accordance with all applicable state, federal and other regulatory agency requirements.

**X Ray Manual**

**Civil Rights Policy and Procedures:**

- Policy and Procedures FOR COMMUNICATION WITH PERSONS OF LIMITED ENGLISH PROFICIENCY
- Policy and Procedures FOR COMMUNICATING INFORMATION TO PERSONS WITH SENSORY IMPAIRMENTS
- Policy and Procedures FOR NONDISCRIMINATION
- GRIEVANCE Policy and Procedures
- EMPLOYMENT APPLICATION Policy and Procedures
Job Descriptions
For all Staff
- Front Desk
- Insurance Billing
- Accountant
- Biller
- Cleaning
- Massage Therapist

Job Descriptions Pt benefit Specialist

Monitoring
- 1. Based on assessment of risk
- 2. Used as a management tool
- 3. Day-to-day activities within the office
- 4. Scalable to the risks and resources
Step Four: Auditing and Monitoring

- Auditing
  1. Implement risk evaluation and auditing techniques
  2. Best if done by an outside entity so as not to be biased
  3. Must be independent and objective

MEDICAL RECORD AUDIT Policy and Procedure

- PURPOSE: A medical record audit will analyze claim development and submission from patient admission to claim submission. Should the purposes of the audit include the following:
  - Ensure compliance with legal and regulatory requirements.
  - Determine the accuracy of billing and reimbursement practices.
  - Identify areas for improvement in documentation and coding.
  - Ensure that services provided are medically necessary.

- POLICY: A base-line audit will be accomplished at least annually consisting of 10 medical records per provider. The necessity for subsequent internal follow-up audits will be determined according to errors identified in the base-line audit. Audits will be conducted by an outside consulting firm under Client/Attorney Privilege. Audit reporting will include the following:
  - Audit Report by provider.
  - Provider education will be conducted for all identified errors.
  - Recommendation for follow-up audit activity based on the following:

<table>
<thead>
<tr>
<th>Error Rate</th>
<th>Schedule for Follow-Up Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>Annual</td>
</tr>
<tr>
<td>20%</td>
<td>8 months</td>
</tr>
<tr>
<td>30%</td>
<td>6 months</td>
</tr>
<tr>
<td>40%</td>
<td>4 months</td>
</tr>
<tr>
<td>50%</td>
<td>2 months</td>
</tr>
<tr>
<td>60% - 70%</td>
<td>1 month</td>
</tr>
<tr>
<td>80%</td>
<td>60 days</td>
</tr>
<tr>
<td>90%</td>
<td>2 months</td>
</tr>
<tr>
<td>100%</td>
<td>30 days</td>
</tr>
</tbody>
</table>

- Risk assessment

  - Follow the claim from the initial documentation to the claim submission.
    - Were the codes billed and reimbursed accurately ordered?
    - Were the services performed?
    - Were the services reasonable and necessary for the treatment of the patient? (Medically necessary)
    - Focus on highest revenue and highest volume services.

Reminder

- If an overpayment or billing error is identified, a provider has 60 days to repay the amount.
- Patient Affordable Care Act Section 111(d)(2)(A)(ii)
- If repayment is not made, penalties can be up to three times the amount of overpayment and additional $1,100 per claim.
- Patient Affordable Care Act.

Reminder

Exclusion List

- What to do if an employee is on the list?
  - Temporarily remove them from providing services involving government programs.
  - Discuss with legal counsel.
  - Refund money to government if appropriate.
  - Review exclusion documents. What did they do?
  - Return employee after exclusion is expired.
Step Five: Lines of Communication

- Qui Tam/Whistleblower
  - Must have a whistleblower policy
  - Non-Retaliation policy
  - Who do they respond to?
    - Management
    - Compliance Consultant
    - Compliance hotline

Whistleblower Policy (WP)

- Positive employee relations and morale are achieved best when there are
  in a working atmosphere of ongoing open communication between
  management and supervision and staff.
- The employee’s views are important
- The WP will encourage employees to come forward and communicate
  problems, concerns and opinions without fear of retaliation or retribution.
- When reporting to the OIG, the person can report anonymously
  www.oig.hhs.gov
  1-800-HHS-TIPS

Policy

- Just saying that one has an open-door policy is not enough
- Employees must be given a range of reporting options
- Cell phone has caller id
- E-mail has caller id
- Answering machine
- Forms
- Compliance officer
- OIG hotline

Code of Conduct

- “First among equals”
- Fundamental statement of the organization’s values and standards
- The most public of the organization’s compliance statements
- Demonstrates the organization’s ethical attitude
- Should be written plainly (8th grade level)
- Tailored to the business culture or identity
- Foreign language, Braille, sign language

Anderson Chiropractic Clinics are committed to providing quality, comprehensive health care to the
patients of our community. Our services will be provided in a professional manner within a safe and
orderly environment. All personnel will be expected to maintain high moral and ethical standards and
abide by the State and Federal regulations as they pertain to the delivery of health care. All personnel
will adhere to the Compliance Program of Anderson Chiropractic Clinics. If there is any suspicion of fraud
or abuse in the delivery of health care, the person can report anonymously to the OIG hotline.

Step Six: Enforcing standards through well publicized disciplinary guidelines.
**PURPOSE:** Establishment of disciplinary actions for violations of the Compliance Program encourages strict adherence of state or federal laws, statutes, or regulations.

**POLICY:** Inappropriate behavior, conduct or activities will result in penalties or disciplinary actions.

- Failure to report inappropriate behavior, conduct or activities will result in penalties or disciplinary actions.
- Penalties will be fair and consistent. Mitigating circumstances will be taken into consideration.
- All providers, practice personnel, vendors, contractors or other individuals or entities providing health-related services will be informed of the consequences of violating the Compliance Program.
- Each case will be evaluated to determine the severity of the violation allowing for any unusual or mitigating circumstance.
- All disciplinary actions will be under the supervision of the Compliance Officer.

**Disciplinary Guidelines**

<table>
<thead>
<tr>
<th>Offense</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Offense, minor or mitigating circumstance</td>
<td>Documented oral warning</td>
</tr>
<tr>
<td>Second Offense, minor or mitigating circumstance</td>
<td>Additional Education; retraining</td>
</tr>
<tr>
<td>Third Offense, minor or mitigating circumstance</td>
<td>Written Reprimand</td>
</tr>
<tr>
<td>Fourth Offense, minor or mitigating circumstance</td>
<td>Termination</td>
</tr>
<tr>
<td>First Offense, serious or severe</td>
<td>Probation Period or termination</td>
</tr>
<tr>
<td>Second Offense, serious or severe</td>
<td>Demotion or termination</td>
</tr>
<tr>
<td>Third Offense, serious or severe</td>
<td>Termination</td>
</tr>
</tbody>
</table>

**Step Seven: Responding promptly to detected offenses and undertaking corrective actions.**

**ALLEGED NON-COMPLIANCE INVESTIGATION**

- Detailed and swift investigation of alleged non-compliance complaints or discoveries of erroneous internal procedures will preserve the integrity of the Compliance Program and allow for the implementation of corrective measures.
- The investigative process will include:
  - The Compliance Officer is responsible for investigative procedures.
  - Every alleged complaint will be evaluated to determine whether a violation of the Compliance Program or other state or federal healthcare law, statute or regulation has occurred.
  - All investigations will include the assessment of monetary loss to any healthcare program and whether regulatory disclosure is required.
  - Erroneous overpayments will be disclosed and funds returned to the identified carrier or payer within ninety days of discovery.
  - The effectiveness of the Compliance Program will be evaluated for each allegation of non-compliance allowing for implementation of corrective actions if necessary.
  - Compliance Program policies and procedures will be reviewed at least annually to detect any procedural weaknesses and make appropriate improvements.

**REGULATORY INVESTIGATION**

- Personnel will remain calm and fully cooperate with any subpoena or search warrant presented to the practice by agents of state or federal regulatory authorities. Legal counsel is available to personnel requesting representation during the investigative process.
- The investigative process will include:
  - Management of the search and seizure process by the Compliance Officer.
  - Complete cooperation of all personnel is required. Any statements made to authorities must be true and accurate. Only authorized personnel are allowed to provide documents to regulatory authorities.
  - Personnel are required to inform the Compliance Officer of any contact by regulatory authorities away from the clinic premises.

**HIPAA**

- HIPAA General Rule 164.502
  - A covered entity may not use or disclose protected health information except as permitted or required by this subpart or by subpart C of part 160 of this subchapter.
  - Covered Entities (160.103)
    - Health Plans: A plan that provides or pays the cost of medical care. Includes Medicare, Medicaid and self-funded plans. Does not include plans with less than 50 participants administered by the employer.
    - Providers: A provider of medical or health services that transmits or receives health information in electronic form.
    - Clearinghouses: Process health information from a non-standard content into standard data elements or to a standard transaction. Does not include third party administration.
HIPAA Privacy Rule minimum necessary standard "requires covered entities to evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosures of PHI."


HIPAA Security Regulations call for implementation of procedures to regularly review records of system activities, such as audit logs, access reports, and security incident tracking reports.

Implementation of hardware and software access

Business Associates

- A business associate is an independent contractor (not an employee) that creates, receives, maintains or transmits PHI for a function or activity regulated by HIPAA on behalf of a covered entity or another BA.
- A BA is also an individual or entity that provides, operates, or controls, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, or financial services that requires access to PHI for its services.
- Anything a covered entity or BA could do itself, but has someone else perform the service that involves access to PHI is considered to be a BA. If the service involves creation, receipt, maintenance, or transmission of PHI, then in most circumstances, they will be considered a business associate.
- You must have an updated Business Associate agreement that outlines what to do in case of a breach. There is a decision tree that must be followed to determine the extent of the breach, if it has to be reported and to whom.

- The Office of the National Coordinator for Health Information Technology (ONC) recognizes that conducting a risk assessment can be a challenging task. That’s why ONC, in collaboration with the HHS Office for Civil Rights (OCR) and the HHS Office of the General Counsel (OGC), developed a downloadable SRA Tool [exe - 91.3 MB] to help guide you through the process.
- This tool is not required by the HIPAA Security Rule, but is meant to assist providers and professionals as they perform a risk assessment.
- www.healthit.gov/providers-professionals/security-risk-assessment-tool

Top 10 Tips to Get Started in HIPAA

- Establish a Network
- Have an appropriate budget
- Develop and implement a HIPAA Privacy and Security training program
- Have a Disaster Recovery and Business Continuity Plan
- Have a Breach Response and Notification plan
- Maintain system activity and audit logs and periodically review for any abnormalities
- Ensure each employee has a unique user ID and does not share it
- Enforce a password policy with complexity, length, and time requirements
- Harden your physical security to limit access to equipment and systems
- Track, monitor, and audit your business associates

Password Protection
- Strong Passwords • Capital letter(s)
- Number(s)
- Special Character(s)
- Not first name

HHS has issued new guidance required by HIPAA that can help organizations prevent, detect, contain, and respond to threats, including:

- Conducting a risk analysis to identify threats and vulnerabilities to electronic protected health information (ePHI);
- Establishing a plan to mitigate or remediate those identified risks;
- Implementing procedures to safeguard against malicious software;
- Training authorized users on detecting malicious software and report such detections;
- Limiting access to ePHI to only those persons or software programs requiring access; and
- Maintaining an overall contingency plan that includes disaster recovery, emergency operations, frequent data backups, and test restorations (all are required standards of HIPAA to be in compliance).
Next Webinar

ICD 10 and Medicare Update

October 26, 2017 @ 12:30

Student-Doctor Networking Reception

- Event: Student-Doctor Networking Reception
- Date: Saturday, September 16th
- Time: 5:00-7:00 pm
- Location: Event sponsored by Palmer College of Chiropractic
- Description: Join us for drinks and appetizers. Doctors meet your potential new hires. Students, come and introduce yourselves to potential employers. Now is the time to network. Relax after a long day of classes. The winner of the Dr. Kenneth Luedtke Scholarship will be announced. Don't miss this opportunity to connect with the next generation of brilliant minds.

Christopher R. Anderson DC, MCS
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Thank you!