Avoiding the Most Expensive Documentation Mistakes

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Who is this guy?

- Graduated NYCC 1989
- Established DCMDPT practice in 1995
- Owned 5 practices
- Practice Management Coach for 25 years
- VP Broward County Chiropractic Society
- Focusing on Solutions, Not Fear!
- I am NOT the police!
- Proudly sponsored by Eclipse Practice Management Software

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Get all the notes and goodies!

- Scan the QR code
- Access the notes and all the resources I promise during this session right away.

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Do You Feel Like This?

4

Or This?

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No Fear!

- This material is not meant to invoke fear
- It is meant to inform
- Knowledge is Power
- If you know where your pain-points and weak spots are you can take specific action to turn the weaknesses into strengths
- Approach how you practice from a position of power
- It doesn't have to be hard!

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We've come a long way!

- No standardization
- Very little detail
- Not much was required by carriers
- Good insurance 80/20 with $100 deductible
- Bad insurance 80/20 with $250 deductible
- It was almost like throwing HCFA's in the air and it would rain checks!

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And then it happened…..

- This thing called managed care happened
- Insurance carriers started to actually look at what we were doing
- As a profession, we stuck our heads in the sand and pretended it would all just go away
- Some of us still feel that way!
- But it didn't go away…and it got worse!

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Why Did This Happen?

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The OIG's Findings

- In 2016 the OIG determined that 82% of all chiropractic services were not considered medically necessary
- Medicare's findings were a bit better at 51.2% error rate
- Improper coding (98940,98941 or 98942 for all patients)
- Insufficient documentation
- Billing for maintenance care
- High potential for upcoding

Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

HUNDREDS OF MILLIONS IN MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES DID NOT COMPLY WITH MEDICARE REQUIREMENTS

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On February 3, 2017, the Department of Justice (DOJ) issued a Final Rule to increase the civil monetary penalties assessed under the False Claims Act (FCA), due to inflation for the year 2017, to an all-time high of $10,957 (minimum) to $21,916 (maximum). Thirty years ago, in 1986, Congress amended the False Claims Act to provide the government with a more effective way of protecting against false claims and fraud in waste and abuse of federal monies used to fund healthcare programs like Medicare, Medicaid, and TRICARE.

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We had to prove necessity!

- What did you do?
- Why did you do it?
- Was it necessary?
- Did you code it correctly?
- Was documentation sufficient?
- We were waiting for the next shoe to fall!

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The "EHR Incentive Program"

- Made it easy for DC's to enter the age of technology
- The government was going to pay
- Of course, there were strings attached
- Meaningful Use and PQRS
- There was a move towards standardization
- Many thought this was finally going to be the way we could prove that chiropractic was better and more cost effective

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Audits Are Here

- Post Payment audits are a tactic utilized by government and private insurance payers to extract money previously paid to doctors.
- Insurance profitability experts believe that payment audits are as successful in building insurance companies' profits as raising premiums or adding members.

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Who Can Be Audited?

- Any provider who received insurance payments regardless of in-network or out-of-network status.
- In-network: Right to audit stems from provider agreement.
- Out-of-network: Right to audit stems from case law, statutes and regulations.
- Cash practices are not exempt from compliance with the standard of care and documentation requirements.

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What Can Trigger An Audit?

- Provider profiling
- Complaint by a disgruntled patient
- Complaint by a disgruntled employee
- Practice advertising
- Submission of claims for care of family members and/or employees
- Random selection

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A Georgia Case

- DC owns a practice that has several massage therapists employed as W2's
- He discovered 7 years ago that the local police department has excellent coverage for manual therapy if performed without CMT and with the Rx of a medical provider
- He markets to the local police and quickly this becomes a nice additional source of revenue.
- Manual therapy (97140) alone contributes over $350,000 a year in revenue from the police
- Pretty nice, huh?

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A Georgia Case

- Since he was ranked the top biller of 97140 in Georgia, he appeared very different from his peers
- The insurance carrier took a peek
- The documentation is all they looked at
- The notes did not match the diagnosis (majority of areas worked on were outside the area of dx)
- Subjective was non-specific
- Muscles were not specifically identified (cervical, thoracic, etc)
- No signature by LMT on the notes
- An original Tx plan with Rx was made at the onset of care, but most services were performed months after the Tx plan expired
- Pre-Printed on the SOAP note form stated "3 Units"
- Everyone got the same number of units of 97140

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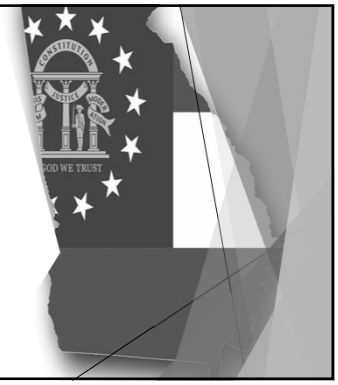
A Georgia Case

- The insurance carrier did a deeper dive of 100 files and found exactly the same issues with the documentation on every date of service.
- It was determined that it was most likely massage therapy (97124) that was performed
- A 6-year extrapolation was performed and an initial demand of $2.1 Million was made
- The attorney brought me in to see what can be salvaged.
- This audit is happening now, but we have so far succeeded in establishing medical necessity for 1 or 2 units of 97140 in most cases and the demand for refund is now "only" $594,000.
- The fight is not over, but this doctor is no longer taking his documentation in such a casual manner.



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Let's Look At Our Core Codes: CMT

- Until the mid-1990's DC's had one code to describe any and all adjustments
- A2000
- CMS helped our profession to create a new code set to allow DC's to better describe the level of care we provide with our adjustments
- 98940 = 1-2 Regions
- 98941 = 3-4 Regions
- 98942 = 5 Regions
- 98943 = Extra-spinal Adjustment

Seems pretty easy, right?
But we're chiropractors…….

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CMT Codes

- Medicare expected that DC's would report these new codes with certain frequencies

98940 = 35-40%

98941 = 45-55%

98942 = 5-10%

How do you measure up compared to these expectations?

The amount that you vary from the expected norms can raise the likelihood of your practice getting looked at.

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A Florida Case

- Florida DC who practices in an area with VERY high Medicare population
- In passing he mentions to me that he bills for 98941 100% of the time
- Whenever a practice is 100% of anything, it give pause for concern
- Upon review of his documentation, it was found that almost 100% he was documenting medical necessity for a 98940!
- Full Spine Adjuster?
- Need to consider that part of his treatment was therapeutic, and part was actually a wellness service.
- Compliance Activity Log was implemented

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The Fun Continued….

- Six months after correcting his coding practices he got a "love note" from Medicare
- Asked for a small sample of specific patients with specific date ranges
- They found what I had found
- They took a deeper dive and requested 100 patient files
- Six Year Extrapolation!!
- Medicare could have demanded a refund for all the money paid for 98941 services
- They "only" demanded the difference between payment for 98941 and 98940

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How did it play out?

- Because he did a pro-active claims and documentation audit BEFORE Medicare did their audit, Medicare looked very favorably upon the situation
- Implementation of a Compliance Program has an average effect of decreasing penalties by 67% nationally
- This doctor was able to negotiate a 90% reduction in his refund
- $25,000 is a whole lot better than a quarter million!
- Be aware that the codes you use today can have a very real impact on you and your practice even years from now!

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EHR can help in many ways

- Enhanced reporting and statistical management
- Improved communication between providers and insurance carriers
- Easier appointment management
- Establish standards within the software
- Minimize or eliminate short cuts or missed steps

But we're chiropractors, right?

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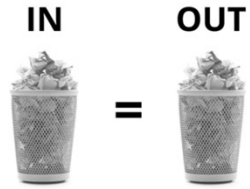
Our Noble Profession

- We are known to be the worst documenters
- Low-hanging fruit
- Auditors know that a peek into almost any practice will yield easy pickings
- GIGO

Garbage Documentation,
Garbage Reimbursement



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We can do better. It's not hard!

- The "S" in SOAP
- Perhaps the easiest fix
- Go just a bit beyond LBP ⬆
- Keep it FUNCTIONAL
- Ask "what were you doing when you noticed your low back pain was worse?"
- Use direct quotes!

"Patient reports increased low back pain after vacuuming their living room yesterday."

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No "Copy and Pasting" Notes!

- What we do can be repetitive
- Many are struggling to keep up with documentation despite great software
- Too many of us have become accustomed to "copy and paste"
- Auditors are aware of this and are looking for it
- Make sure your notes look like a live person had something to do with the creation of each and every note…every time!

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A South Carolina DC

- Finally decided it was time to do his own compliance audit
- Asked me to do his baseline, first-time audit and report back my findings
- Every patient had their entire first visit note "copy and pasted"
- This included performing initial exam, x-rays, and history into every note
- Each visit read like it was the first visit!
- Even the typos were identical!

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Colorado Multidisciplinary Practice

- Chiropractor, Nurse Practitioner, Physical Therapist
- Correctly operating under one single tax ID number
- Previous history of post-payment audit failure
- Desired to get on the right track

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Colorado MDP….

On a patient's initial date of service, the patient was seen by:

1. DC: consultation, exam, adjustment
2. NP: consultation, exam, three trigger point injections to rotator cuff
3. PT: initial evaluation, passive modalities, therapeutic exercise

Patient was placed on a treatment plan for physical therapy and was seen three times per week for four weeks.

What do we see as problems so far?

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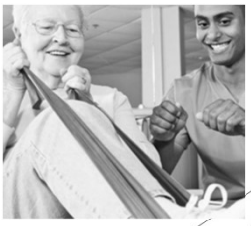
Colorado MDP….

The physical therapist was very busy and used the feature built into the software that allowed for "copy and paste" from the previous note.

This particular software created the CPT codes and billing driven off that day's notes. Great time saver, but……



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Colorado MDP….

- Every service from the first day was repeated on all subsequent dates of service for ALL providers
- Appeared that the patient saw the DC each visit for an exam and adjustment which they did not
- Appeared that the patient saw the NP for an exam and three TPI's each visit which they did not
- Appeared that the PT did an initial evaluation on each visit which they did not

The software automatically billed out for all services

The patient's insurance paid for all services!!!!

Refund was made to insurance carrier proactively to limit risk of future audit

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Technology in our offices can be an incredible tool

- Imagine your notes projected on a 12' x 12' screen in a court of law
- Do you like what you, the judge, and jury see?
- Make your technology do the best job it can for you by feeding it the best information you can!

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Treatment Plans

- Treatment Plans are NOT the same as Care Plans
- Under CMS guidelines, a treatment plan should be no longer than a 30-day period of time
- It can be shorter than 30 days, but no longer
- It must be written, digitally or on paper, and be easily accessed in the patient's file
- A patient may have several treatment plans as part of their care plan

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Treatment Plan

- Patient's Name
- Name of Insured
- Insurance Info
- Gender/DOB
- Name of Provider
- NPI of Provider
- Modalities to be performed (CPT)
- DX codes as reported on CMS1500
- Pertinent exam/imaging findings
- Short-term goals (from OATs)
- Long-term goals (from OATs)
- Treatment duration and frequency (how many visits per week for how many weeks)

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THAT'S A BEAUTIFUL THING,.

Treatment Plan

- If the treatment plan is readily accessible to your billing department most requests for additional information can be handled without the biller having to request from the doctor.
- Biller can simply send the treatment plan along as it will likely contain the information that is needed to properly process and pay a claim.

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Medicare Modifier AT

- "Active Treatment"
- Used when you believe Medicare should pay for this adjustment
- When part of an overall treatment plan
- The first Wednesday of every month at 9:00 AM is NOT a treatment plan
- There must be functional therapeutic benefit expected

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Medicare Modifier GA

- "Got ABN"
- Used when you believe that care will be considered wellness
- No further functional improvement expected
- Only used for services that are otherwise covered by Medicare
- 98940, 98941, 98942

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Advance Beneficiary Notice

- Possibly the most misused piece of documentation in all of Chiropractic
- Patient signs it once
- On day the patient begins wellness care
- Do not have patient sign on first visit
- Do not have patient sign on every visit
- Once signed, it is valid for indefinitely* or until the patient has an exacerbation or a new condition (returns to AT modifier)
- Changed on October 14, 2021!
- Improper use of ABN renders it invalid and you may be liable to refund money to the patient
- * Current ABN expires in June 2023

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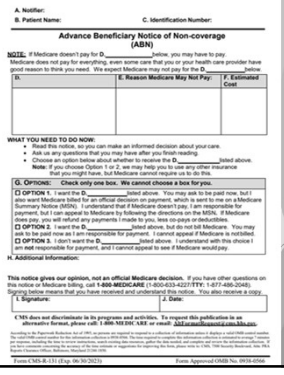
ABN

- The previous ABN expired on June 30, 2023
- The current ABN has been released and has been in effect since August 1, 2020
- Looks similar but is not the same
- New version expires January 2026
- www.cms.gov for current version



A. Notifier:
B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D___ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D___ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D___ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D___ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D___ listed above. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the D___ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: ABNformatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 06/30/2023) Form Approved OMB No. 0938-0566

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Medicare Modifier GY

- GY = "Got Your ABN"
- Not the CMS ABN
- Used for statutorily non-covered services that are never covered by Medicare
- Tells Medicare that you know this service will not be covered, but you are reporting with the GY modifier for denial and possible consideration by the patient's secondary/supplement
- This is your own internal form that spells out financial costs for these non-covered services
- Makes good business sense!
- Want mine? Email me! drjefflewin@gmail.com

Name of Practice
Address, Phone, web information
Advanced Notice and Agreement of Patient Financial Responsibility
(Voluntary Advance Beneficiary Notice)

Patient Name: | DOB:

Your doctor has recommended the following treatment plan to facilitate the best recovery from your current condition. The expected advantages of receiving the care and the disadvantages of not receiving the care have been discussed with you and you have indicated he/she has adequately answered any questions you may have.

Unfortunately, each insurer has different opinions about what care is and is not medically necessary. This makes it difficult to accurately determine the amount that will be reimbursed by the insurer and the amount for which the patient is responsible for payment until the insurer process the claim and makes payment. The resources required to render the care and appeal their decisions exceed the potential reimbursement.

Treatment Plan and Estimated Costs

I want this service (Patient initials)	Service	Frequency	Duration begin/End Date (Estimate)	Estimated Cost if Billed to Insurance	Estimated Co... Prepaid / Pa... Time of Ser...

Options

Do you want the services you have initiated? Yes / No
Do you want your insurer(s) billed? Yes / No Medicare Advantage Plan Yes / No Other insurer
Do you understand you are financially responsible for charges not paid by your insurer? Yes / No

	I want the services that I have initiated. Please bill my insurer. I accept financial responsibility for services not paid by my insurer.
	I want the services that I have initiated. Do NOT bill my insurer. I accept full financial responsibility.
	I do not want the services I have not initiated

Additional Information:

Patient's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

A copy of this form is given to the patient at the time it is signed.

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Modifier GP

- Placed on any modality or therapy service performed in your office (97XXX)
- Let's the carrier know that this service is part of an outpatient therapy program
- Some services may require both GY and GP
- Some private payers are already starting to require this
- Watch your EOB's for unusual denials of your 97XXX codes
- May be due to need to add GP

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Medicare Again!

- Regardless of your philosophy…
- Your notes must contain documentation of the presence of subluxation
- Document by X-ray
- Document via PART
- If using PART, you must clearly state the components of PART you are using
- Need at least two of the four
- One of the two MUST be either "A" or "R"
- Could be both!

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Writing Your Diagnosis

- There is an art to writing a diagnosis
- The Hierarchy
- List your diagnoses in decreasing "value" order
- The diagnosis you place in position "A" determines how this care plan will be handled by payer
- These rules may vary if payer has specific rules (Medicare)
- How is the value of a diagnosis determined?

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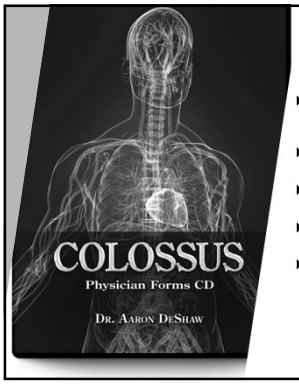

Colossus

- Computer program used by most major auto payers to determine the value of a case
- Makes use of AI in its determinations
- Depends on identifying value drivers from your documentation
- It has profiles on you, your practice, and the attorneys you work with!
- Private payers use Colossus or programs that function just like it.

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Assessment: Writing Your Diagnosis

- Neurological: radicular, neuritis, neuropathy
- Structural: spondylosis, spondylolysis, DDD, DJD, scoliosis
- Functional: decreased ROM, muscle weakness, deconditioning syndromes
- Soft Tissue: muscle spasms, myositis, myofascitis
- Extremities
- Sprains and Strains
- Subluxation/Segmental Joint Dysfunction

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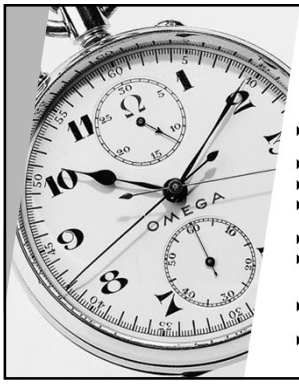

Counting Therapy Minutes

- Be sure to count therapy minutes where appropriate
- Any 97XXX code that is 97032 or higher
- First unit begins with the 8th minute
- Second unit starts at the end of the 23rd minute
- Third unit begins with 38th minute
- A single service performed for less than 8 minutes is not billable, but must still be documented
- Multiple services or multiple units require you to calculate total treatment time.
- Simply record number of minutes

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Counting Therapy Minutes

- Patient receives:
- 10 minutes of Manual Therapy (97140)
- 10 minutes of Therapeutic Exercises (97110)
- 8 minutes of Ultrasound (97035)
- Total Treatment Time = 28 minutes
- Falls into the 2 Units of Timed Codes Range
- Bill for one unit each of 97140 and 97110
- Ultrasound is not billable but must still be documented (time, intensity, region performed)

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How Hard Was This?

- Clearly, much of this is common sense
- The key is to actually pay attention to what you are doing and not doing!
- Realize what you document (or neglect to document) can have very real impact on your practice even years later
- Just Do It!

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Need help? Let's Talk!
Your Solution on Your Terms!
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