THE FUTURE DC: 9 INSIGHTS TO A MORE EFFICIENT PRACTICE



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chiropractic economics

It's that time of the year and it seems crazy to think we only have a few weeks left of 2016. This year has flown by but I believe that we have accomplished many things in 2016 and I am excited about the new technology and changes we will see in the coming year of 2017.

It is my pleasure to be involved with the release of the "The Future DC: 9 Insights to a More Efficient Practice." It is always very exciting to look back over the year and see how far the industry has changed in such a short amount of time.

I believe some of the major transformations the industry has seen throughout the last year was the growth of technology use in practices. It is very important for practices to stay up to date with the newest technologies. Not only to better help providers spend less time at their desk, but to ensure they are staying on top of their privacy and security.

One of my major goals this year was to provide useful knowledge to providers about data analytics and how much they can help your practice. I will continue to travel to different conferences throughout 2017 and would like to invite you to come talk to me about technology, analytics, and business processes for your practice. My goal for 2017 is to continue searching and designing new technology to help providers within their practice, whether that be to easier process claims, analytic awareness, business processes, staying compliant for HIPAA, and up to date with audits and fraud.

Infinedi has been working for the last three years to develop and improve your claims revenue management cycle from both a back-end and front-end user experience. Our new and more robust service platform will provide you with new methodologies to review, track, and change the claims stream. When fully released, our new platform will allow you to customize how you, and your office, experience the claims cycle, with options for many intuitive, and configurable reports and queries of your claims information. The enhanced graphical interfaces with a contemporary design will help office staff quickly access comprehensive results and process flow information on every page. Most importantly, you can work safely and securely as all of our services are fully covered by HIPAA and accredited by EHNAC (www.EHNAC.com).

"It is very important for practices to stay up to date with the newest technologies. Not only to better help providers spend less time at their desk, but to ensure they are staying on top of their privacy and security." – Brad Cost



Please take the time to read the following articles, and please feel free to download my webinar over these same topics. You can find it on chiropracticeconomics.com.

To learn more about Infinedi or Infinedi Analytics, visit Infinedi.net or call 844-321-8312.

Sincerely,
Brad Cost
President/CEO of Infinedi

CONTENTS











4 If you aren't using data and analytics in your practice, you should be

7 Security: The promise and challenge of electronic data

9 Wearable tech: What it is and why it affects you

11 Financial viability: Getting paid with new payment models

13 7 common questions about value-based healthcare and what it means for DCs

16 Are you forming the right partnerships in healthcare?

18 OIG Auditor's report: Summary of findings on DC payments

21 The ins and outs of a single payer system

23 5 ways a clearinghouse has your back

IF YOU AREN'T USING DATA AND ANALYTICS IN YOUR PRACTICE, YOU SHOULD BE

By Casey Nighbor

You may think that data and analytics are not things that chiropractors need to pay attention to.

Perhaps you believe that data should only be analyzed by bigger companies or those with more time or know-how. But data can be critically useful to you and your practice. Not only can it help grow your business but it can help you keep patients as well as attract new ones.

Data will also become critically important as the healthcare industry continues to evolve towards value-based care and reimbursement. Understanding data and analytics now means you won't be left behind later.

WHAT IS BIG DATA?

The term "big data" is often thrown around as a buzzword, but what does it actually mean? Big data refers to the ability to collect and analyze large and complex datasets to uncover new insights about the world around us.[1] For each industry it can mean different things and the opportunities to use big data are seemingly limitless.

Big data can "decode human DNA in minutes, find cures for cancer, accurately predict human behavior, foil terrorist attacks, pinpoint marketing efforts, and prevent diseases," says Bernard Marr,

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bestselling author and analytics consultant.

While you may not be curing cancer with the data you gather at your practice, data is still valuable to you and your business. But just knowing you should collect data isn't enough.

Gathering the right data and knowing what to do with it is equally important.

POINT TAKEN

Gathering the correct data points is crucial to being able to analyze them meaningfully. While every practice is different and data may slightly vary on needs, there are some data points you should consider examining.

Jay Greenstein, DC, CEO of Sport and Spine Rehab and his team gather a large variety of data to analyze, which in turn helps grow the practice.

"Every week we are looking at the typical chiropractic visits, billings, revenue, number of patients, and other types of detail data like billings per visit, retail sales, proportion of active and passive care, patient satisfaction, online review data, etc.," he says.

R.T. Donahue, president of Collaboration Health Care, agrees but also sees data as being valuable to you as a business manager.

By collecting "objective internal and external data points you can drive staff meetings and stay personally responsible to achieve your goals and help set goals for your staff," he says.

Donahue also recommends collecting data on the percentage of patients who complete your recommended care plan, your most frequent billing errors and how much they cost you, and codes other providers are using that you rarely use.

Now that you've collected the key data points, how do you analyze them to be useful to you and your practice?



TECHNOLOGICAL RELIEF

Having software to help you make sense of the data you've collected is an invaluable time-saver. But not all software is created equal.



Collect data on the percentage of patients who complete your recommended care plan, your most frequent billing errors and how much they cost you, and codes other providers are using that you rarely use.

"We have lots of data and luckily our software program has features that allow us to configure any element of data in our system and run reports based on a number of variables," Greenstein says. "I would encourage any DC when they are looking at new technology to have it integrated and able to run reports on any variable in the system. That really helps you understand your business because questions will come up and you can pull specific points to answer them."



Customization is also an important factor for Donahue, who recommends that you find

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software with key performance indicators (KPIs) that help you. Ask things about your software such as "can you customize your data collection to zero in on areas that interest you, how long does that take, and how easy is it to get the KPIs you want?"

By being able to pull specific data reports from your software, you can readily address problems in your practice.

"Let's just say your revenue is low one month, and you don't have the ability to determine why your payer or class of payments are under-performing, then how do you know how to fix the problem?" Greenstein says. "You have to drill down into the data and know where revenue is low compared to billing to easily identify the claims and then fix the problem by getting those claims paid."

Using the correct software means you can take vast amounts of data and turn it into a valuable resource that not only benefits your business but also your patients.

BACK TO BUSINESS

Data collection provides critical information to support financial and operational decisions in your practice.

Gathering data about your business means that you will know the ins and outs of your practice in objective terms. Instead of just thinking that the practice is doing well or not, you will have hard data to show you where your strengths and weaknesses lie.

"If DCs actually take the time, they can not only build their business with data but also drive more patients to the practice" Greenstein says.

PATIENTS FIRST

Data can also help with patients because using clinical data can help improve care. Analyzing data from your practice to see how you can

improve visit times and patient satisfaction as well as things like online reviews can lead to happier patients when they have better outcomes. With better outcomes come strong referrals that help your practice thrive.

Using data to power your practice also means that you stay competitive in an ever-crowded healthcare market. "If you aren't thinking about continuous improvement and how you can deliver better outcomes for your patients, you'd better start," Greenstein says. "Otherwise you are going to be at the bottom of the barrel."

You have to drill down into the data and know where revenue is low compared to billing to easily identify the claims and then fix the problem by getting those claims paid.

DATA DRIVEN

Using big data for your practice doesn't have to be intimidating, but it is something you should be paying attention to. Collecting the correct data points and having software to make sense of the information you gather are critical to making the best use of your practice data. By using data analytics, you are not only helping your business but you are also ensuring that you are providing the best possible patient care. ■

REFERENCE

1. Logi Analytics. "What is Big Data." http://www.logianalytics.com/bi-trends/what-is-bigdata. Published Oct. 10, 2013. Accessed July 11 2016.



SECURITY: THE PROMISE AND CHALLENGE OF ELECTRONIC DATA

By Kaitlin Morrison

Security and privacy issues have always been a prominent concern, but the rapid growth of EHR systems and the use of data analytics are increasingly creating opportunities for data compromise to occur.

Information systems have so much untapped promise for the future of healthcare and data security professionals are witnessing profound changes in the security needs of healthcare practices. Data security must now work harder and become smarter to survive.

Preventing the next cyberattack is no easy feat and requires special expertise. Electronic data may hold promise for healthcare, but weak security is healthcare's greatest new threat and ongoing challenge.

A GROWING THREAT

Cyber attacks are no longer science fiction and for healthcare practices today, they represent an ever-present reality. This past year, many prominent organizations such as Premera, Anthem, UCLA Health, Excellus, CareFirst, and others announced significant data breaches.

With so many large healthcare organizations experiencing data breaches, the new total number of patient records compromised within the past five years now exceeds 143 million. In 2015, more than five times as many hacking incidents occurred than in 2010, or 57 compared with 10, respectively.

In fact, 99 percent of all individuals who were impacted by data breaches in 2015 were victims of a hacking incident. The Ponemon Institute estimates that hospitals, clinics and doctors lose more than $6 billion each year to cyber attacks. Their recent report highlights the size and scale of this problem--90 percent of the participating organizations they surveyed

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were victims of cyber attacks within the past two years, with almost half were attacked more than five times.

Strong security is the answer. Because security threats present themselves inside and outside of the office, it is more important than ever to be ready and prepared. Good security is not an event--it is a process, and an essential part of every healthcare and chiropractic practice.

BE READY

Thankfully, there are resources and tools available to help you protect yourself, your practice, and your patients. Just as the security threats are bigger and scarier, the security solutions are now more powerful and insightful than they were before.

Staying ahead of security breaches requires today's EHR vendors, billing and claims clearinghouses, and other companies that store, process, and use healthcare data to use next generation security. Looking for the right vendors who understand these important responsibilities and commitments is essential.

Healthcare data security is also much more than securing your EHR system. Being proactive and thoughtful about information security may help you identify problems before they occur. Your own due diligence is an essential part of combating cyberattacks and preventing breaches.

Conducting audits, eliminating points of access for unauthorized users, and enlisting the help of your staff and partners prepares you to address upcoming security challenges.

RENEWED COMMITMENTS

If you still need to really commit to protecting your patients' data, you can start by conducting a security audit to assess your current level of risk and identify preventative steps to take and changes to implement in your office practices, physical security and technology use. The Federal Government's HeatlthIT website has information about how to conduct your security risk assessment.

From there, you can begin making changes to your practice based on how well you performed. You should also ask your EHR vendor how you can partner with them to strengthen your computer security practices. Keep in mind that all computers should be kept physically protected as well. If you use other types of devices such as smartphones and tablets or other easily-stolen portable EHR portals, these should also be kept away from unauthorized access.

Start by conducting a security audit to assess your current level of risk and identify preventative steps to take and changes to implement in your office practices, physical security and technology use.

When every practice, vendor and healthcare community stakeholder makes a commitment to protecting data, information security, and privacy become a more realistic promise for America's healthcare system. The future of healthcare will likely bring many more data breaches, but together we now have more we can do to protect patients. ■

REFERENCE

HealthIT Dashboard. "Breaches of Unsecured Protected Health Information." The Office of the National Coordinator for Health Information Technology. https://dashboard.healthit.gov/quickstats/pages/breaches-protected-health-information.php. Published: February 2016. Accessed: December 2016.

WEARABLE TECH: WHAT IT IS AND WHY IT AFFECTS YOU

By Kaitlin Morrison

Among the many technological changes occurring in healthcare, consumer technology is beginning to change how patients use primary and specialty care. In an age when health becomes increasingly commoditized, the popularity of personal healthcare devices presents an opportunity for patient care to leave the office and follow patients along throughout their busy lifestyles.

Now, more data and a more accurate understanding of patient health and behavior is available, often in real-time.

With these devices, patients are bringing along health tests wherever they go. Without in-office tests, patients can continuously monitor their sleep cycles, blood pressure, physical activity, and more. Implantable and wearable devices are becoming a popular way to become more aware of blood pressure, exercise, activity levels, and even blood sugar levels.

For healthcare practices, these trends mean more accessible information and more health-savvy patients. Of course, more technology also means a greater need for education as more people begin paying attention to their health data and begin trying to interpret that information.

ENGAGING CONSUMER HEALTH TECH IN YOUR PRACTICE

Patients who use health technologies to help them improve their health present an opportunity for your clinic. You can engage your patients in health-improving behavior modifications and provide them

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with encouragement by teaching them to track their own health metrics.

If your patients struggle to lose weight, for example, a wearable tracking calorie usage, exercise, and food logging can help them understand which daily changes contribute to the most to their goals.

You can also encourage your patients to use positive reinforcement by establishing small competitions and rewards for patients who meet their goals. Whatever technology they use, see if you can help them understand more about how it works and the best way to use it to improve their health.

SELF-DIAGNOSIS IN THE WEARABLE AGE

If more patients know basic information about their health, they can make more informed decisions. Most patients are not healthcare professionals, though, so they need your guidance in order to interpret all of the new data they now have access to.

This represents an opportunity for you to provide education and advice on how to use wearables and consumer health technology. While these new tools can boost patients' interest in and engage with their healthcare, they can also be misused and misinterpreted.

Some patients may attempt to self-diagnose or may simply believe their data demonstrates good health when something is actually very wrong.

Wearables can never replace doctors or DCs, or at least not for the foreseeable future. Patients who use health technology to replace primary care appointments or validate their beliefs about their health status may be vulnerable to making mistakes that can cost them their good health.

Even if patients interpret the data correctly, the information itself could be inaccurate. Consumer wearable devices are not always as accurate as medical-grade instruments. If your patients claim to discover something about their health using wearable technology, ask them for more information.

If your patient claims they are sick and can prove it with their wearable, ask them how they arrived at their conclusions. Let them know that you are happy to help them become more involved in their care, so you plan to listen to their concerns and, as necessary, examine them or refer them for additional testing.

While these new tools can boost patients' interest in and engage with their healthcare, they can also be misused and misinterpreted... Some patients may attempt to self-diagnose or may simply believe their data demonstrates good health when something is actually very wrong.

THE FUTURE OF WEARABLE AND IMPLANTABLE TECH

In the future, more wearables and implantable technology will likely enter the market. Monitoring health outside the healthcare practice will probably grow in popularity and become an increasingly common part of how healthcare is provided.

Along the way, you can use this as an opportunity to help patients understand how their bodies work and how to stay healthy. ■

REFERENCES

Campbell, K. "Fitbit in healthcare: Is more data better?" KevinMD Blog. http://www.kevinmd.com/blog/2014/07/fitbit-health-care-data-better.html. Published: July 2014. Accessed: December 2016.

Wang, S. "Fitbit's Move Into Medical Gadgets Risks Attracting FDA Scrutiny." Bloomberg Technology. https://www.bloomberg.com/news/articles/2016-04-15/fitbit-s-move-into-medical-gadgets-risks-attracting-fda-scrutiny. Published: April 2014. Accessed: December 2016.

FINANCIAL VIABILITY: GETTING PAID WITH NEW PAYMENT MODELS



By Kaitlin Morrison

Healthcare payments and reimbursements are undergoing rapid change as the U.S. healthcare system is reworked and adjusted. Many providers are wondering how these changes will impact their own income sources as insurers change their payment systems and Centers for Medicare & Medicaid Services (CMS) begins implementing the provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the Merit-based Incentive Payment System (MIPS).

These changes can seem confusing whenever the old financing system was active for so long as the default means of paying for healthcare.

DCs should be aware of how these changes impact the business side of their practices. Knowing how to help your practice through these transitions can make a significant difference in receiving payment.

You deserve to be paid fairly for your services, so be sure to understand how these changes are going to impact your own income.

CURRENT AND FUTURE MODELS

With significant support for changing the Affordable Care Act (ACA), keeping it the same, repealing it, or replacing it with different legislation, the American public appears to be very interested overall in finding and implementing an effective payment model for healthcare.

What this model will eventually look like is not entirely certain, but a few main ideas present serious contenders. A fully-public, single-payer model has moderate support and would represent a major overhaul of the American healthcare system if it were ever implemented. Hybrid models like the system we currently have could also be modified to increase access or give public funding a larger role.

Most likely, private insurers will remain a significant source of healthcare funding, at least for now. Some of these insurers are experimenting with different methods of packaging payments to clinics and practices. Here are a few different types of models being used or studied right now:

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FEE FOR SERVICE (FFS): Each service is paid for, individually, by the insurer. Payments are regularly made to providers after services are billed.

CAPITATION: For each patient, the provider receives a set rate that may vary by the patient's age, gender, or other characteristics. The amount may be more or less than the actual cost of providing care.

EPISODE-BASED AND BUNDLED PAYMENTS: A single episode of care, such as short-term treatment for a specific condition, is grouped together and a single payment for all services is paid by the insurer. Bundled payments group together all the multi-specialty care of a single episode, also, so if your practice has other specialists who also helped your patient, you will receive a single payment for all services.

PAY FOR PERFORMANCE: This is a supplementary model in which clinicians are provided incentives or fined part of their reimbursement based on specific performance metrics.

RETAINER: Patients pay a set amount regularly and receive health services. This is also called a subscription or concierge care.

SHARED SAVINGS: This is a type of supplementary incentive model that rewards clinicians or fines them based on cost of care during a particular period.

Sometimes, medical homes and accountable care organizations (ACOs) are also mentioned as payment models, but these are really just different organizational models that can be paid in different ways depending on the needs and structure of the organization.

Medical homes and ACOs are typically paid using FFS with additional patient care management fees or shared savings incentives contributing to their pay.

Which model is best for you depends on the needs, size, location and other characteristics of your practice. Before you choose a model or a hybrid of the models listed here, be sure to do your own research and obtain professional advice as needed.

Which model is best for you depends on the needs, size, location and other characteristics of your practice. Before you choose a model or a hybrid of the models listed here, be sure to do your own research and obtain professional advice as needed.

STAYING INFORMED

CMS regularly posts updates to their website about changes to Medicaid and Medicare, private insurance and other issues. This website can help you understand why certain changes are being made, who they specifically apply to and how to provide comments or concerns directly to CMS during public comment periods.

Being proactive about researching your payment system options can help you avoid difficulties later on, so it is worth the effort to learn more. ■

REFERENCES

Newport, F. "Majority in U.S. Support Idea of Fed-Funded Healthcare System." Gallup, INC. http://www.gallup.com/poll/191504/majority-support-idea-fed-funded-healthcare-system.aspx. Published: May 2016. Accessed: December 2016.

Friedberg, M; Chen, P; et al. "Effects of Health Care Payment Models on Physician Practice in the United States." Rand Corporation and American Medical Association. http://www.rand.org/content/dam/rand/pubs/research_reports/RR800/RR869/RAND_RR869.pdf. Published: March 2015. Accessed: December 2016.

7 COMMON QUESTIONS ABOUT VALUE-BASED HEALTHCARE AND WHAT IT MEANS FOR DCS

By Catherine Hanson

With 2017 quickly approaching, the topic all DCs should be paying attention to is value-based healthcare and the changes it will bring to the profession.

Here are the most common questions about value-based healthcare and how DCs can start making changes now.

1. HOW WILL ALTERNATIVE PAYMENT MODELS (APMS) AND MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CHANGE HEALTHCARE?

The Medicare program has been attempting to move from a fee- for-service, pay-for-volume system to a "pay for value" system for the last several years. Initial efforts focused on "carrots" or financial incentives for healthcare professionals to adopt electronic health record (EHR) software systems and report quality results. However, in the last couple of years, those programs, such as meaningful use and PQRS, have morphed into penalty programs. A new

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bonus and penalty program, which added cost-effectiveness to the mix, the Value-Based Modifier (VM) program, has also been added.

MIPS increases the stakes. The new MIPS program will consolidate all three programs into a single program with four performance categories— quality, advancing care information, clinical practice improvement, and resource use. Commencing with the 2017 performance year, MIPS will increase the stakes, and then in 2019, 2017 MIPS performance will be translated into a Medicare payment rate.

For each of the next several years, potential MIPS penalties and bonuses will both increase. During this entire period, the base Medicare fee schedule will be frozen, and complete MIPS results will be publicized on Medicare's Physician Compare website, visible to all patients and payers. Thus, for many healthcare professionals, successful MIPS performance will be critical to the economic viability of their practices.

The APM option. Medicare has provided an alternative to MIPS: participation in an "Advanced Alternative Payment Model." Healthcare professionals who participate in Advanced APMs have the potential not only for bonuses but also for downside financial risk. Together, APMs and MIPS will likely force DCs to fully embrace health information technology and data analytics, to more aggressively adopt and implement best practices, and migrate to clinically—if not financially—integrated systems where they can better manage the health of patient populations.

While the transition to value-based payment does require a dramatic shift in thinking and the implementation of new technologies and practice patterns, it is not rocket science.

2. WHY ARE THESE CHANGES OCCURRING IN HEALTHCARE? APMs and MIPS were the direct result of the passage of the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA. The fundamental reason for the shift to value-based payment systems is the payers' belief the U.S. spends far more on healthcare than other industrial nations without achieving offsetting benefits, making it increasingly hard for U.S. companies to compete in the global marketplace.

3. ARE PROVIDERS PREPARED FOR THESE CHANGES? While the transition to value- based payment does require a dramatic shift in thinking and the implementation of new technologies and practice patterns, it is not rocket science. Moreover, shifting efforts away from maximizing the number of services to ensuring patients instead get the right care at the right time is perfectly aligned with chiropractors' ethics and professional aspirations. Assuming new payment models will indeed reward DCs for engaging in the necessary planning, outreach, and care coordination activities that were never compensated in the past, the move to value-based

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payment will be a win for patients and the providers who care for them.

4. HOW CAN DCS PREPARE TO BE A PART OF THE CHANGES? Here are some steps to take now to achieve the practice redesign and transformation necessary for success:

Evaluate your current patient population. In order to optimize the care your patients receive, you need to understand them as a group as well as individuals. Generally speaking, there will be relatively few diagnoses and relatively few services that account for the bulk of your practice, and relatively few truly high-risk patients. By knowing that information, you can focus your care coordination efforts where they will make the most difference.

Select some appropriate evidenced-based clinical guidelines and quality measures. Once you know the treatment areas of most importance to your practice, pick relevant clinical guidelines for implementation.

Measure your results and implement changes as warranted. Value-based payment is based on your results, not on how many services you provide. Take the steps necessary to ensure your patients are doing as well or better than those of your peers.

Implement a robust HIT system. All value-based payment systems will require you to report on your outcomes and communicate electronically with your patients.

5. WHY IS DATA SO IMPORTANT TO THE FUTURE OF THE PROFESSION? "Value based healthcare is all about achieving better outcomes, lower cost, and higher levels of patient satisfaction. All of these things have data attached to them," says Jay Greenstein, DC, CEO of Sport and Spine Rehab. "These points will be used to show how they add value to the system and also how we as a profession collectively aggregate that information and demonstrate to the payers how we provide more value to the system. Data makes it very clear to someone who is paying our bills that we are way more cost effective, we get better outcomes, and our patients are more satisfied, and therefore benefits should be designed to send a certain population to a chiropractor first. That is not an opinion if it comes from analytics."

Generally speaking, there will be relatively few diagnoses and relatively few services that account for the bulk of your practice, and relatively few truly high-risk patients.

6. WHAT TYPES OF DATA WILL START TO BE CRUCIALLY IMPORTANT WITH THESE CHANGES? You need to know what your patient population looks like as a whole, so you can eliminate gaps in care and provide extra support for those who face significant health challenges. You need to know what percentage of the time you adhere to best practices and your patients are compliant. You need to know what your patients and your referring providers think about you.

7. WHAT ARE SOME DATES AND DEADLINES THAT PROVIDERS NEED TO START PAYING ATTENTION TO? Although MIPS will not affect your Medicare payments until 2019, that impact will be based on your performance commencing January 1, 2017. ■



ARE YOU FORMING THE RIGHT PARTNERSHIPS IN HEALTHCARE?

By Kaitlin Morrison

New best practices are emerging that encourage different organizations, vendors, and providers to form partnerships together for better healthcare. These best practices are being developed as a result of new data, technological development, population research, and financial pressures and opportunities.

For many providers, this new level of collaboration provides renewed opportunities to help patients and demonstrate the value of quality care.

Forming strong and effective healthcare partnerships requires a high degree of understanding, flexibility, and communication. Each member should be respected for their contributions to the group and should benefit from the partnership. As needed, members may also need to change their own attitudes and be willing to revisit assumptions they hold about healthcare.

You can find potential partners who share your vision for a meaningful and valuable healthcare partnership and begin to see these benefits in your own practice.

PARTNERSHIPS WITH OTHER SPECIALTIES

Many providers learn their teamwork skills from their professional education courses, which often teach students to fit into particular roles and responsibilities. This practice can distract providers from the true reason for partnership in the first place.

Caring for the needs of the patient is the top priority of quality healthcare, but focusing only or primarily on fulfilling a role can create a distraction from that purpose. This can discourage teamwork and the type of communication necessary to serve the patient's best interests.

Time-sensitive care can be a particular area of concern where communication

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and teamwork can make a difference in outcomes. Teams that fulfill their own roles effectively as individuals, but fail to successfully communicate could be failing patients. If, for example, a chiropractor who is referred a patient by a medical doctor performs an exam and first adjustment but fails to fully communicate all of their findings to the MD, the other doctor may not have all of the right information to continue helping the patient. It is not enough to just fulfill a role. There must also be an appreciation for the shared goal of patient treatment.

PARTNERSHIPS BETWEEN ORGANIZATIONS

Alongside multi-specialty partnerships, collaboration between different organizations is another means of working together. You can share methodology, learn how your peers are running their clinics, and create your own referral network of trusted organizations. If you do any type of exchange of patient information or share a formal partnership in some area, be sure to establish your agreement in a contract to protect the interests of all parties. You may need to abide by additional government regulations regarding any partnerships you create, so be sure to have an attorney or other qualified professional advise you as needed.

Before entering an agreement where you bill together for services, be sure to examine carefully how financial reimbursements, rewards, and obligations are divided and shared. It is also vital to have clear, upfront expectations for the partnership that every member understands and fully agrees with.

ON THE SAME PAGE

Before finding another provider or group to partner with, start by ensuring that each member is joining the team for the same reason and with shared values. Each member must be free to pursue their own patients' health without concern for causing offense or frustration.

Patient, provider, organization, and vendor rights and responsibilities should all be respected and acknowledged. ■

Alongside multi-specialty partnerships, collaboration between different organizations is another means of working together. You can share methodology, learn how your peers are running their clinics, and create your own referral network of trusted organizations.

REFERENCE

Valentine, M and Edmondson, A. "Improving on-the-Fly Teamwork in Health Care." Harvard Business Review. https://hbr.org/2016/11/improving-on-the-fly-teamwork-in-health-care. Published: November 2016. Accessed: December 2016.

OIG AUDITOR'S REPORT

SUMMARY OF FINDINGS ON DC PAYMENTS

By Chiropractic Economics staff

In a report dated October 2016, the U.S. Department of Health and Human Services Office of Inspector General (OIG) announced that "hundreds of millions in Medicare payments for chiropractic services did not comply with Medicare requirements."

Based on the OIG's review of payments to chiropractors, it was determined that 82 percent of payments made in calendar year 2013 were unallowable. As Medicare Part B paid out nearly $439 million for chiropractic services, during the period under review, the office estimates that $358.8 million should have been disallowed. The report notes that these overpayments were made "because CMS's controls requiring chiropractors to include the AT modifier and initial treatment date on claims were not effective in preventing payments for medically unnecessary chiropractic services."

Office of Inspector General, U.S. Department of Health and Human Services. (PRNewsFoto/Office of Inspector General Department of Health and Human Services)

Kathy Mills Chang, a certified medical compliance specialist and certified professional chiropractic coder (MCS-P and CPCC), says, "The challenge is not the AT modifier or the updating of 'box 14' with the new initial treatment date of an episode. The real problem is the DC understanding which care is 'medically necessary' according to Medicare's definition and which care would be defined as 'maintenance care' per Medicare's definition. The care is actually not 'unnecessary' but perhaps better defined as 'not medically necessary' and therefore, doesn't qualify for reimbursement from Medicare but rather is the patient's financial responsibility."

Specific problems identified by the Medicare administrative contractors (MACs), who process Part B claims for CMS, fell mostly into the following categories:

1. **MAINTENANCE THERAPY.** CMS guidelines state that acute subluxations of the spine may require up to three

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months of active treatment. Treatments beyond this time period are considered maintenance therapy, which is not a service covered by Medicare Part B. According to Chang, these are called "screens," whereby Medicare sets internal parameters for certain diagnosis codes to identify when most cases should be complete. "This alerts them that any care beyond that might be approaching maintenance care, and therefore, the provider may receive a request to justify with additional documentation why this case requires more care than another," Chang says.

2. **FAILURE TO DOCUMENT MEDICAL NECESSITY.** Even though patient records were submitted with the AT (acute treatment) modifier, upon investigation it was determined that the treatments provided did not warrant this coding. "This is truly the No. 1 problem with documentation and Medicare in our profession. It's that the doctor may consider care 'medically necessary' and therefore coverable, so they bill Medicare with an AT modifier indicating active treatment. However, the notes do not warrant active treatment and fail to establish why the care meets Medicare's definition."
3. **EXCESSIVE TREATMENTS.** A 2005 OIG report determined that a typical patient presenting for acute treatment requires approximately no more than 12 treatments. Although at this time CMS does not specify a maximum number of treatments, any number more than 12 is considered to be likely medically unnecessary, and after 24 treatments that likelihood is extremely probable, according to the report.

CMS does not specify a maximum number of treatments, any number more than 12 is considered to be likely medically unnecessary, and after 24 treatments that likelihood is extremely probable, according to the report.

4. **UNNECESSARY SERVICES.** Despite the education for chiropractors available on CMS and MAC websites, chiropractors were found to be billing for services not covered by Medicare. According to Chang, the training on these websites is insufficient with respect to chiropractic services, "and various consultants train these concepts differently."

POSSIBLE REMEDIATION OF OIG REPORT

The Office of Audit Services (OAS), which prepared the report, recommends that "strong controls" be enacted to prevent payments for medically unnecessary chiropractic treatments. Specifically, the office suggests that a limit on the number of treatments would have sufficed to prevent the majority of the overpayments in question, and mentions an annual number of 30 visits per patient as a target. In the event a chiropractor

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exceeded that number of treatments with a given patient per annum, CMS would need a system to identify such services for additional review.

In response, CMS balked at this suggestion, citing unspecified obstacles that would prevent the implementation of such a system at this time.

The report stressed the need for additional training and education for chiropractors so that the AT modifier is used correctly.

And finally, in the event a certain limit on the number of services CMS will allow per patient cannot be arrived upon, the report recommends a system for tracking the date a patient begins an episode of care, and flagging for review any treatments that exceed a reasonable timeframe (e.g., 90 days).

"Certain MACs have listed 24 annual visit allowances that serve as a screen," Chang notes. "At least these doctors know how to stay within the lines and when to make the patient financially responsible for the adjustments as maintenance."

In communication with the auditors, CMS concurred that setting a limit on the number of chiropractic services is desirable, but putting in place a system to identify cases that exceed that number is a step requiring a National Coverage Determination. CMS also agreed that additional clarification on the proper use of the AT modifier will reduce the incidence of overpayments for chiropractic services and will work through "local educational activities" to realize that objective.

For doctors of chiropractic who would like to review the essentials of compliant coding immediately, the American Chiropractic Association offers a training module titled "Medicare Documentation: Just Tell Me What to Do!" This training is designed for practicing doctors, new practitioners, and students, and offered for a small fee. For more in-depth training on Medicare compliance and billing, professional consultants are available in the chiropractic industry.

The statistical relevance of even a small data set is important in today's world as it defines the government's perception of chiropractic, and correct coding is essential now more than ever before.

It should be noted that the OAS only audited a total of 105 billings to CMS totaling $2,447, and extrapolated this out to the $359 million figure cited in the report. Brad Cost, CEO of Infinedi Electronic Data Interchange, notes that the statistical relevance of even a small data set is important in today's world as it defines the government's perception of chiropractic, and correct coding is essential now more than ever before. And Chang sums up the issue in two points: incorrect documentation and lack of understanding of the definition of medical necessity versus maintenance care.

Ultimately, while CMS may have found the contested claims to have not established medical necessity, this may have been largely due to documentation inadequacies, and not evidence of intentional misconduct. ■

THE INS AND OUTS OF A SINGLE PAYER SYSTEM



By Kaitlin Morrison

Now and then, talk about implementing a one-payer system in the U.S. enters public discourse. Among patients, clinicians, and policy-makers this model is controversial. Advocates believe this system would increase healthcare access, reduce care disparities, and reduce cost by utilizing economies of scale created by enrolling all Americans in the same insurance coverage. Opponents point to concerns about federal overreach, possible cost increases, and problems with healthcare quality.

Regardless of where you personally stand on the issue, understanding more about this model can help you learn more about the challenges facing today's healthcare system and how policymakers are trying to respond.

Regardless of where you personally stand on the issue, understanding more about this model can help you learn more about the challenges facing today's healthcare system.

A NATIONAL SINGLE-PAYER SYSTEM

According to a 2016 Gallup poll, 58 percent of Americans are open to the idea of a federal payer system. There is a sizable number of Americans, in other words, who believe this is a better way to pay for healthcare. The model many proponents put forth is a Medicare-for-all type of system, where the existing framework of the Medicare Program would be adapted and expanded to provide coverage for all Americans. Healthcare providers would be encouraged to accept this form of public insurance.

In response, depending on how the system would be implemented, clinicians may choose to accept the single-payer insurance or offer concierge, cash-only care.

STATE SYSTEMS

Another form of single-payer insurance would be state-based. In 2016, Colorado

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voters considered and ultimately rejected a proposal to create a state-wide single-payer health insurance system. The plan would have allowed private clinics and hospitals to operate but would create a taxpayer-funded insurance plan with a mandatory ten percent payroll tax split between employers and employees.

Similar plans could be adopted in the future by individual states as an alternative to the ACA. These plans, if they are structured like the Colorado idea, would operate alongside public plans, such as Tricare (insurance for people serving in the military and their families) and Medicare. Medicaid, which is governed on a state-by-state basis, could disappear into the state's public plan. State residents traveling outside the state would, in theory, continue to receive care paid for by their home state's plan.

LOOKING TO THE FUTURE

A change to a single-payer system would represent significant change inside a system that is now composed of many different payers and insurers. Private insurance, if such a system were created, could disappear or dramatically change, as would billing and EHR systems. It could increase demand for healthcare if more patients who previously did not have access to healthcare began obtaining services.

However, a single-payer system may also deny more services in the interest of cost-containment. Such a transition would likely take an extended period of time as the many different pieces of the current healthcare system would be fit together into a single funding source.

Regardless of what happens, substantial changes to our healthcare system are likely to continue. Insurers are experimenting with different payment models while Medicare is experiencing change under MACRA and MIPS.

Regardless of what happens, substantial changes to our healthcare system are likely to continue. Insurers are experimenting with different payment models while Medicare is experiencing change under MACRA and MIPS.

New ways of funding healthcare are likely to remain a top priority of our healthcare system and therefore are a priority for clinicians to understand. Educating yourself and making your voice heard will help shape the future progress of healthcare funding. ■

SINGLE PAYER

REFERENCES

Newport, F. "Majority in U.S. Support Idea of Fed-Funded Healthcare System." Gallup, INC. http://www.gallup.com/poll/191504/majority-support-idea-fed-funded-healthcare-system.aspx. Published: May 2016. Accessed: December 2016.

Ingold, J. "Amendment 69 in Colorado: What you need to know about ColoradoCare." The Denver Post. http://www.denverpost.com/2016/09/23/colorado-amendment-69-coloradocare/. Published: September 2016. Accessed: December 2016.

5 WAYS A CLEARINGHOUSE HAS YOUR BACK

By Kaitlin Morrison

Submitting billing claims is likely a key part of managing your chiropractic practice.

As such, it is vitally important that every aspect of processing your claims is completed securely, accurately, and efficiently. While filing paper-based claims is certainly an option, electronic claims processing has several significant advantages.

Electronic processing may improve the business side of your clinic. You could save money, work more efficiently, and protect your practice from serious issues and errors. Protecting yourself from unnecessary liability and reducing your risks helps you continue caring for patients.

Manual claims submission depends on you or your office staff to code correctly and prevent mistakes. Without electronic claims processing, you may miss problem claims altogether. Claims processing protects your practice.

1. **COMPLIANCE.** Creating manual claims that fully comply with HIPAA and other local, state, and federal laws can be difficult and tedious. Electronic processing through a clearinghouse can help you stay compliant with your claims by running each claim through a full checklist of regulatory standards before it is submitted. This provides an additional safeguard and helps your practice to file claims that are consistently compliant.

2. **ACCURACY.** Rather than risking claims errors that can cost you additional processing time and resources, electronic processing ensures that

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every claim is accurate and complete. Manual processing introduces unnecessary human error. You are solely responsible for reviewing your claims and making needed changes. This lengthens the claims process and results in less accuracy.

Inaccurate manual claims also take longer to fix and resubmit than electronic claims because manual claims are sent back to your practice through the mail. This process is less efficient than electronic processing. Improving both your billing accuracy and your practice's efficiency at the same time is possible and may dramatically improve your business.

Doing your own routine self-audits can help protect and prepare you. By using an electronic claims clearinghouse, your practice can rely on secure processing that helps you become audit-proof.

3. **AUDIT-PROOFING.** Your practice should always be audit-ready. With so many aspects of your office to manage, bad claims practices may be overlooked until it is too late.

Doing your own routine self-audits can help protect and prepare you. By using an electronic claims clearinghouse, your practice can rely on secure processing that helps you become audit-proof.

4. **BUSINESS ANALYTICS.** Electronic claims allow you take advantage of business analytics tools. Now, even small practices can use data analysis to understand their businesses better and make smart decisions. Tracking informs you of status changes and shows data on key aspects of the financial side of your practice by letting you to review claims information.

You will have at-a-glance access to the information you need. Instead of waiting for results through the mail, you can see real-time information about your claims. With these tools, you can direct your focus to other important revenue issues.

5. **INTEGRATION WITH EHR AND PRACTICE MANAGEMENT SOFTWARE.** A claims clearinghouse system can be seamlessly integrated into your existing EHR or practice management software, so you can efficiently submit claims for review and processing. You can easily import data and prepare your claims quickly and efficiently. On paper, this process may be significantly slower from claim creation to approval and reimbursement.

OVERALL BENEFITS

Electronic claims processing helps you to automate your practice. You can catch and prevent more errors, reduce administrative time, and improve billing efficiency. By having a system in place to improve the claims process, you are reducing your own workload and increasing the time you can spend seeing patients and doing other important tasks.

If you are ready to revitalize your practice's administrative processes, consider how electronic claims processing can help your clinic achieve more. This technology might just make a significant difference for your practice. ■

REFERENCES

American Medical Association. "The benefits of electronic claims submission–improve practice efficiencies." AMA. https://www.stepsforward.org/Static/images/modules/20/downloadable/claims-flyer.pdf. Published 2013. Accessed November 2016.

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