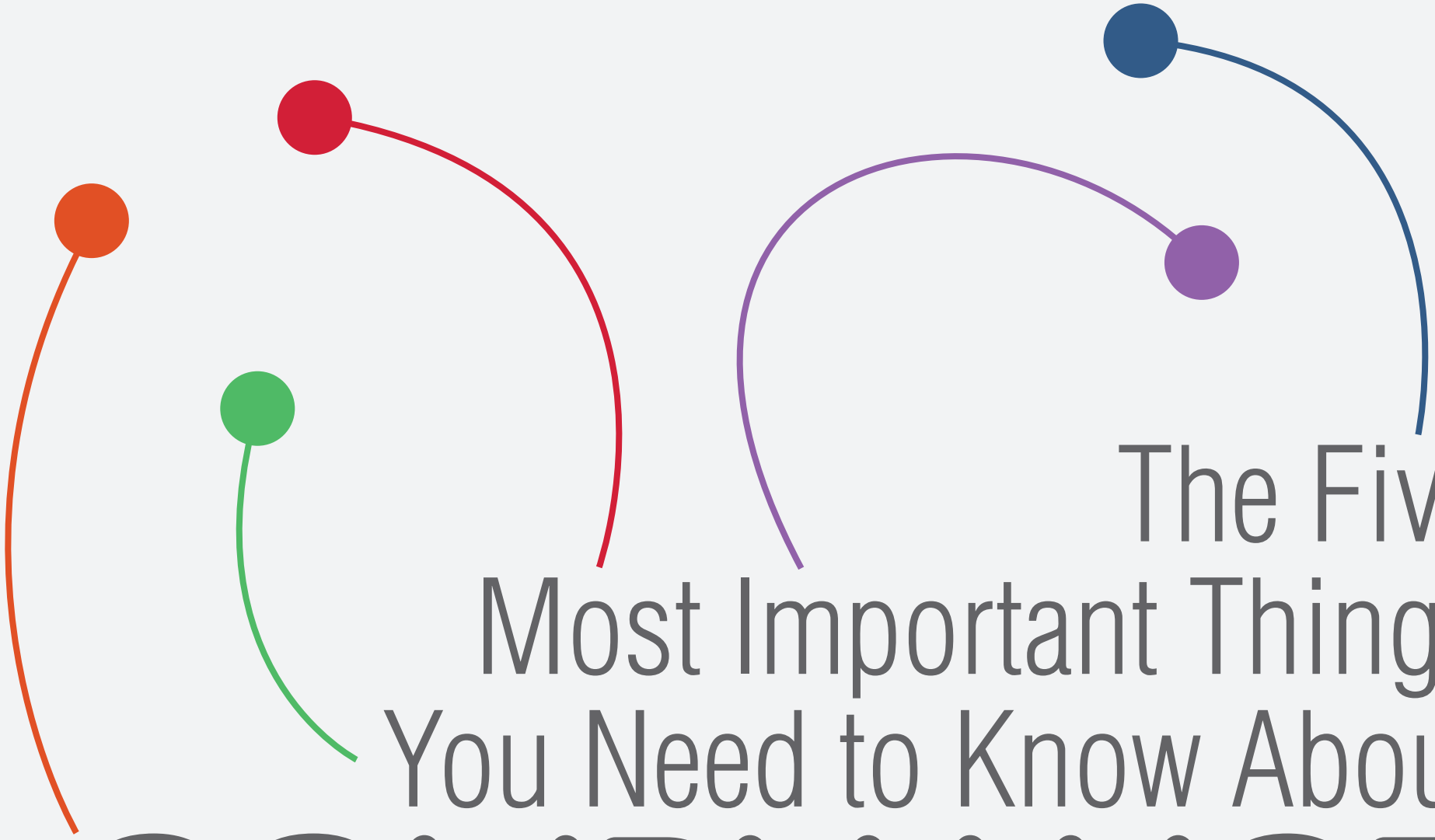
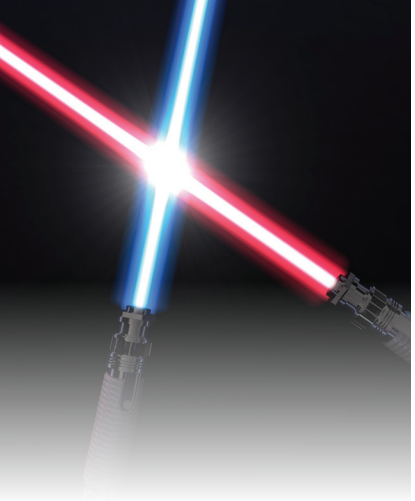


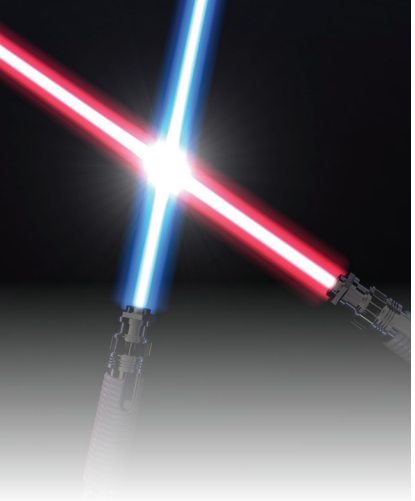
The Five Most Important Things You Need to Know About COMPLIANCE



Make Sure You Are Not the Droids They're Looking For

Make no mistake about it. The Office of the Inspector General has urged The Centers for Medicare & Medicaid Services (CMS) to go on the hunt. In a September, 2015 report, the OIG stated that chiropractic services have the highest improper payment rates among Medicare Part B services. And it has found that 40 to 47% of payments were for what was later determined to be non-covered maintenance therapy.

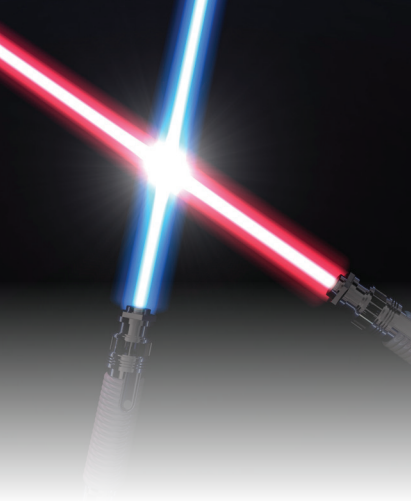
What trips DCs up? Significant things, like using an AT modifier to code care that wasn't actually active treatment. Not really understanding what active care means. Having a ridiculously high ratio of 98942 (five spine region) codes, when the OIG says your percentage of 98942s should be 10% or less. Seeing patients more than a dozen times over the course of a year (yes, really!). Confused yet?



It's Also the "Small" Stuff

For every DC that makes a huge mistake, there are many more who get tripped up by relatively small errors, such as one number off on a code, failure to update a patient's insurance information, reflexive overuse of a particular treatment, a missing signature, etc. While a single instance may not flag you for investigation, a pattern of things being "off" in any way will.

Whether you had intent to defraud, were simply ignorant of a changing regulation, or made a series of clerical errors, you will be judged by what's in your documentation (or not!), and not by what's in your heart or your head. Why? Because launching an investigation or audit costs money, and at the very least, auditors are determined to recoup their own costs. It's not likely they'll pat you on the head and tell you that they know you didn't mean to get it wrong.



Policy Protects Your Practice

And that's sad, because the truth is that the vast majority of DCs don't have the slightest intent to defraud. They're simply busy treating patients, and they either don't have the proper policies, procedures, and systems in place to keep the business side of their practice legal and compliant, or they've got documentation riddled with errors due to lack of understanding.

So when it comes to chiropractic documentation, you can forget about fifty or any other number of shades of gray. There aren't any. While slower documentation might help mitigate errors, for the most part, you either got it right—or you got it wrong. And getting it wrong comes with hefty consequences. Let us help you avoid them.

The solution to this dilemma is a properly installed OIG Compliance Program that allows you to find your own mistakes before someone else does. And even if there were mistakes that slipped through the cracks, when you have a viable OIG Compliance Program, you can prove you have no intent to defraud, or make mistakes. In essence, you are "not the droids they are looking for," because you can prove you are trying to do it correctly and compliantly. And *that* is what auditors want to see.

Records Requests Are Serious Business

Because chiropractic offices receive requests for records every day, it's tempting to downplay them without considering that they may well be a precursor to a full-blown audit. These seemingly simple requests can be fishing expeditions on the part of a government entity or third-party payer to see if they can find errors in the way you document medical necessity.

How to handle this? Start with an often-overlooked step: make sure the request is accompanied by a legal authorization for release of information, unless it is covered already as a part of TPO (Treatment, Payment, and Healthcare Operation). Otherwise, this will put you in violation of your own HIPAA policy.

Make Sure Your Records Tell the Full Story

Next, read the request with great care and send only the records requested, along with any other materials that support the "story" the records tell, keeping in mind the "minimum necessary" requirements. This could include the initial examination, history, treatment plan, etc. that began the episode of care that is being questioned.

Take control and lead the reviewer through the information you're providing by synopsizing the data in a Case Summary on top of your packet, and consider using document flags to highlight key data. When you tell a clear and compelling story, the result is much more likely to be favorable for you.

Look, Look, and Look Again

Finally, have a second set of eyes—preferably the DC's—review the information packet. Once you're satisfied that you're presenting your best possible information in the most coherent way possible, send it by certified mail, with a return receipt requested. Follow up as necessary to determine the outcome of the review.

Every records request doesn't lead to an audit, and every audit doesn't automatically lead to recoupment of funds or referral to prosecution. But keep in mind, after the September, 2015 OIG report, records requests are on the rise. It is now not a matter of *IF* you'll get a request, but *WHEN* you'll get a records request. That said, don't take any request for records lightly! Be prepared.

Know What Your Contracted Carriers Consider Medical Necessity

You know what you consider clinically appropriate care. But what you may not know is much more important from a reimbursement standpoint: what does each of your contracted carriers define as medically necessary care? If you have a contract with a third-party payer, make no mistake: it doesn't much matter what you think—by signing up, you've agreed to play by their rules.

Basically, medically necessary care is what the carrier can justify as payable through insurance. It's usually tied to the patient's ability to function, related to certain diagnosis codes, and defined in their medical review policy.

You Decide the Treatment; Payers Decide If They'll Pay

You still have complete autonomy when it comes to deciding what treatment you'll recommend to each patient—but the carrier can and will dictate that portion of treatment for which they'll pay. So treat your patients as your experience and best clinical judgment dictate, but make sure that you only submit the part of your patient's care that aligns with each carrier's medical review policy for reimbursement.

The remainder? That's the part each carrier expects the patient to pay—and it's equally critical that you make sure your patient understands the fees for which they'll be responsible, and why.

The important takeaway here is that the doctor is the link between insurance-covered treatment and treatment that will be the patient's responsibility, because the medical necessity definition is a clinical decision based on how the patient presents. Everything hinges on your interpretation of each carrier's review policy, your documentation of medical necessity—and how well the two match up. This is why it's called Case Management.

Where to Find Review Policies

Medical review policy is usually found in the provider area of each carrier's website. You can search using their website's tools, or navigate to the appropriate section and use key words such as "chiropractic" or a specific CPT code like 98940. For example, many carriers will pay for orthotics. They will tell you upon verification that they are a covered service. But if you failed to read the medical review policy for orthotics, you may have missed the fact that orthotics are only covered if the diagnosis is "diabetes," for example. If you didn't know that, you may be frustrated when your bill is denied for your diagnosis of "plantar fasciitis."

As with everything, you can't know what you don't know. Make it your business to find out. In fact, your practice depends on it.

Get HIPAA-fied

Did you install a HIPAA program over a decade ago and basically forget about it? If so, you're not alone. But there's no safety in numbers here. It's critical that your HIPAA compliance be up to date.

For example, educate yourself about the HIPAA Security Compliance Evaluation and the HIPAA Security Risk Analysis, both required by law and both essential to maintain as a part of your required HIPAA Program. If you create, receive, maintain, or transmit any electronic PHI (Protected Health Information), you must understand the difference between the two. HIPAA's Security Evaluation asks, "Where do we stand and how well are we achieving ongoing compliance in this area?" HIPAA's Risk Analysis, on the other hand, asks, "What's the exposure to our Protected Health Information? What do we need to do in order to mitigate possible risks? Are our backup plans working?"

Put Policies and Procedures in Place

Next, install a Privacy and Security Risk Management and Governance Program. This means that you have policies and procedures in place, update them regularly, and train all team members. This isn't a binder or manual you can buy, although you can use a template to guide you—this is you writing up your individual policies and procedures.

Use those policies and procedures to develop comprehensive HIPAA Privacy and Security Policies and Procedures, including Breach Notification. In plain English, that means detailing exactly what you'll do in the event of a breach, whether minor (team member opens a patient record they didn't need to see) or major (your laptop gets stolen). What safeguards can you put in place to make sure breaches don't happen---and what will you do if they occur?

Don't Forget to Update Your Notice of Privacy Practices

Obvious but often overlooked: update your Notice of Privacy Practices for patients. Many practices have updated internally, but forget to update the actual form that patients sign, your associated Acknowledgement. While you're at it, make sure you've updated your Business Associate Agreements. You can share patient data with Business Associates under certain conditions. Make sure you know the rules!

Finally, when you've evaluated everything, document and correct what needs improvement. HIPAA isn't something that's ever really "all done." It's an ongoing journey. Make sure your seat belts are fastened and all hands are inside the moving vehicle.

Just Because You're Paranoid Doesn't Mean They Aren't Out to Get You

The OIG's 2015-2017 Work Plans state in no uncertain terms that it considers chiropractic documentation inadequate. Their September 2015 report reiterates this. So it should come as no surprise to you to learn that the government and private insurance companies are always looking for money. It might not even shock you to learn that they consider chiropractic and other healthcare offices an excellent place to find it.

That means that you are under threat of an audit not only by the OIG, Medicare, or other third-party payers, it also means that you could be audited simply because a disgruntled employee, competitor, or even one of your own patients reports your office for possible investigation. Oh, and by the way, those private whistleblowers get a nice little fee if the investigation turns up anything even remotely "wrong."

Just Because You're Paranoid Doesn't Mean They Aren't Out to Get You

Whistleblowers Make Money Reporting You

Even the most perfectly compliant practice in the country isn't immune from whistleblowers. All someone has to do is allege that you've committed intentional fraud or unintentional abuse, and your practice can be put under the microscope. And there is financial incentive beyond revenge for doing so.

What would your practice look like, magnified a thousand-fold and with every code, patient chart, and report you've ever written under intense scrutiny? Is your documentation truly bullet-proof?

Clean Up Your Practice Before You Get Caught

If you've answered with anything other than a heartfelt, resounding "Yes!," you need to be absolutely sure you're safe from any investigation that could result in tens of thousands of dollars in recoupments, more money in fines, and even, in extreme cases, loss of license and imprisonment.

Instead of feeling helpless, just waiting for the hammer to fall, empower yourself with exact knowledge of how your practice would look in an audit. Then you can clean up any problems now, before anyone does come looking. Ask us about KMC University's Practice Analysis, including Practice Performance Profile and Three Chart Reviews—our best tools for putting you through a "safe" audit before you ever get hit with the real thing. The KMC University Practice Analysis Combo not only reduces risk, it also finds revenue opportunities left on the table that more than pay for itself. The Return on Investment (ROI) is easily more than a basic 3:1; in fact, we find most of our clients enjoy an ROI of more than 10:1 as they move toward greater compliance.

Just Because You're Paranoid Doesn't Mean They Aren't Out to Get You

chirotouch®

1.800.852.1771 | ChiroTouch.com

Facebook.com/ChiroTouch

@chirotouch

YouTube.com/user/ChiroTouchVideos

linkedin.com/company/chirotouch

KMC UNIVERSITY

(855) 832-6562 | KMCUniversity.com

Facebook.com/KMCUniversity

@KMCUniversity

YouTube.com/KMCUniversity

linkedin.com/company/kmc-university