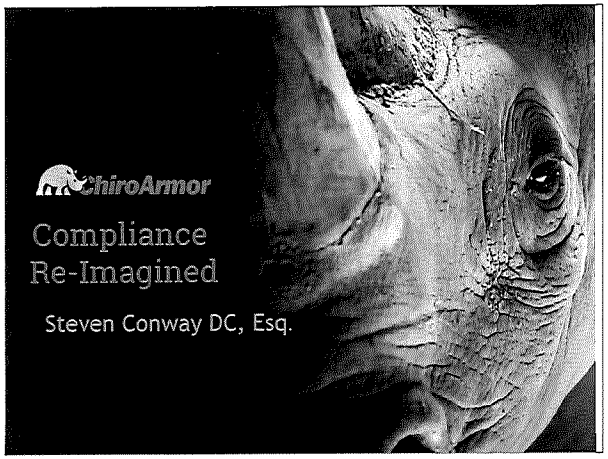

Steven Conway DC, Esq

- Second generation chiropractor
- Past member of the Wisconsin Board of Examiners
- Past member of NBCE Board of Directors
- Current FC4P Board of Directors
- National Medicare parity project.

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Disclaimer

The information provided is designed to provide accurate and authoritative information on the subject matter covered and such information contained herein is provided with the understanding that Dr. Conway is not engaged in the rendering of legal or other professional advice.

Disclaimer

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NCMIC

Problem is the Chiropractic Error Ratio

The historic chiropractic error ratio has hovered in the 80-90% range.

The rest of the healing profession is in the 5-15%

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Problem is the Chiropractic Error Ratio

The primary reasons for the high error ratio:

1. Working with language developed in the 1970s to get chiropractic included into Medicare (not perfect language)

2. Multiple experts telling the profession multiple solutions based on their personal interpretation of the imperfect language.

3. MACs using multiple criteria to determine what is medically necessary or more importantly what is AT vs Maintenance care.

4. Chiropractors not fighting back when care is denied.

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Problem is the Chiropractic Error Ratio

Maintenance:
Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. The AT modifier must not be placed on the claim when maintenance therapy has been provided. Claims without the AT modifier will be considered as maintenance therapy and denied. Chiropractors who give or receive from beneficiaries an ABN shall follow the instructions in Pub. 100-04, Medicare Claims Processing Manual, chapter 23, section 20.9.1.1 **and include a GA (or in rare instances a GZ) modifier on the claim.**

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Problem is the Chiropractic Error Ratio

Maintenance:
Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

"Reasonable Expectation of Functional improvement"

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Problem is the Chiropractic Error Ratio

"Reasonable Expectation of Functional Improvement"

1. Plateau rationale for determining AT vs Maintenance

2. Ability to change goals continuously to keep treatment going and going and going. "I reasonably expect to improve the function of the patient."

3. Focus was on making decisions near the the end of care and not in the beginning.

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Problem is the Chiropractic Error Ratio

OIG Reports: High Intensity search for Medicare Fraud.

"CMS should use targeted tactics to curb questionable and inappropriate payments for chiropractic services."

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Problem is the Chiropractic Error Ratio

OIG Reports: High Fraud Areas:

California
Missouri
New York
Michigan
Illinois
Kansas

Fraud Strike Force operations: Brooklyn, Chicago, Dallas, Detroit, LA, Miami, Southern Louisiana, Southern Texas and Tampa

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Problem is the Chiropractic Error Ratio

OIG report:

Chiropractic services have the highest rate of improper payments among Part B services.

There are 4 hot-spots:

1. Treatment suggestive of maintenance therapy
2. Potential sharing of beneficiaries
3. Potential upcoming of claims
4. Unlikely number of services per day.

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Problem is the Chiropractic Error Ratio

OIG report:

50% of claims reviewed appeared to be maintenance therapy.

2% of the chiropractors were responsible for 50% of the questionable claims. (located in high fraud areas)

Beneficiaries of the high fraud were likely to have also seen PT or OT on the same day.

Most of the suspected chiropractors had previous questionable payments in prior year.

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Problem is the Chiropractic Error Ratio

OIG report:

CMS determined that the high error ratio was due to 5 factors:

1. No documentation
2. Insufficient documentation
3. Lack of medical necessity
4. Incorrect coding
5. Other (errors that did not fit into the other categories)

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Problem is the Chiropractic Error Ratio

OIG report:

Maintenance is the issue.

When asked to identify Active/corrective Treatment (AT) and thereby distinguish it from Maintenance therapy it is useful to identify the start of a new treatment episode.

When chiropractors and reviewers were asked to identify when an episode began and ended.....50% of all treatment episodes remained active throughout the entire treatment of the patient.

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Problem is the Chiropractic Error Ratio

OIG report: Miscoding

Upcoding

41% were upcoded to 98942

15% were upcoded to 98941

"many records did not meet the Medicare guidelines in determining a chiropractic subluxation for each area of the spine treated. The records would indicate a problem in one area of the spine which was examined, but indicated treatment to 3-4 areas of the spine and charged according to procedure without correlation to diagnosis."

Down Coding

OIG and the MACs see charging a 98940 when it should have been a 98941 or 42 as just a serious of an issue. There is an **appearance that you are trying to game the system and falsify your records for some other purpose.**

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Problem is the Chiropractic Error Ratio

OIG report: Documentation

Treatment Plan issues:

"treatment plans are an important element in determining whether the chiropractic treatment was active/corrective in achieving specific goals."

"When reviewing a specific service, we often don't get a treatment plan as if it was crated at the first visit for the episode-this is no more than what we as from medical doctors. *The general trend is that the patient will be treated for several months, 3-4 times per month, but there is no documentation of a treatment plan or any goals.*"

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Problem is the Chiropractic Error Ratio

OIG report: Documentation

11% did not have a subluxation demonstrated on PART

13% did not have a dx of a subluxation

70% did not have a complete patient history.

(just change the DX and go! Issue)

66% did not have a complete description of present illness

63% did not have a complete treatment plan

43% did not have a complete physical exam

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Problem is the Chiropractic Error Ratio

Result:

Increase in Medicare audits such as ZPIC / UPIC:

800 chiropractic offices received a zpic letter.

"we expect your commitment to an effective self-audit and full disclosure of the results. Your refusal to conduct this self-audit or refusal to disclose your audit findings may result in referral to law enforcement for possible civil or criminal prosecution."

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Problem is the Chiropractic Error Ratio

Result:

Increase in Medicare audits such as ZPIC /UPIC:

800 clinics in the Carolinas/Virginias.

2000 clinics audited by Strategic Health Solutions.

OIG audits

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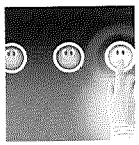
The solution/ hope for the future



1. WPS: Mechanism of Trauma
2. Palmetto GBA
3. NGS: Brooklyn
4. Noridian
5. First Coast
6. Cahaba
7. NCLC historic meeting
8. CMS/Chiropractic working group
9. Universal agreement
10. Training of MAC claims reviewers
11. Training of Chiropractic profession.

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Medicare Compliance

- OIG Exclusion Website
  - https://exclusions.oig.hhs.gov
  - Search for:
    - All new employees before hiring
    - All existing employees quarterly
    - All Business Associates before hiring and quarterly

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Medicare Compliance

- Case #3 U.S. Department of Justice vs chiropractor
- I. M. Friendly, D.C., from nice town, Iowa, and his clinic, Friendly Chiropractic, P.C., have agreed to pay $79,919 to resolve allegations Friendly violated the False Claims Act by improperly billing Medicare and Medicaid for chiropractic adjustments after providing free electrical stimulation to beneficiaries to influence those beneficiaries to receive chiropractic adjustments from Dr. Friendly. The government alleged that this conduct violated the Anti-Kickback Statute and, in turn, the False Claims Act. The claims at issue were submitted between January 1, 2012, and September 30, 2016.

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Medicare Compliance

- U.S. Department of Justice vs Dr. Friendly
- Source of complaint was unknown
- Allegations
  - Inducement by providing free services to Medicare patients
  - Included both AT and Maintenance care in the complaint
  - Coded all maintenance patients as 98940

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Medicare Compliance

- Inducement: Section 1128A(a)(5)
  - This section of the Act bars the offering of remuneration to Medicare or Medicaid beneficiaries where the person offering the remuneration knows or should know that the remuneration is likely to influence the beneficiary to order or receive items or services from a particular providers.
  - The "should Know" standard is met if a provider acts with deliberate ignorance or reckless disregard.

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Medicare Compliance

- Inducement: Section 1128A(a)(5)
  - The "inducement" element of the offense is met by an offer of valuable goods and services as part of a marketing or promotional activity, regardless of whether the marketing or promotional activity is active or passive.
  - For example, even if a provider does not directly advertise or promote the availability of a benefit to beneficiaries, there may be indirect marketing or promotional efforts of information channels of information dissemination such as "word of mouth" promotion by practitioners.
  - In addition, the OIG considers the providing of free goods or services to exiting customers who have an ongoing relationship with a provider likely to influence those customers for future purchases.

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Medicare Compliance

- Under section 1128(A)(a)(5) of the Social Security Act enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a person who offers or transfers to a Medicare or Medicaid beneficiary and remuneration that the person knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner or supplier of Medicare or Medicaid payable items or services may be liable for civil money penalties (CMPs) of up to $10,000 for each wrongful act. For purposes of section 1128A(a)(5) of the Act, the statutes defines "remuneration" to include, without limitation, waivers of copayment and deductible amounts (or any part thereof) and transfers of items or services for free or for other than fair market value.

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Medicare Compliance

- Points to consider
  - First, the OIG has interpreted the prohibition to permit Medicare or Medicaid providers to offer beneficiaries inexpensive gifts (other than cash or cash equivalents) or services without violating the statute. For enforcement purposes, inexpensive gifts or services are those that have a retail value of no more than **$10 individually, and no more than $50 in the aggregate.**

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Medicare Compliance

- Points to consider
  - Second, providers may offer beneficiaries more expensive items or services that fit within on of the five statutory exceptions:
    - Waivers of cost sharing amounts based on financial need;
    - Properly disclosed copayment differentials in health plans;
    - Incentives to promote the delivery of certain preventive care services;
    - Any practice permitted under the federal anti-kickback statute
    - Waivers of hospital outpatient copayments in excess of the minimum copayment.

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Medicare Compliance

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Medicare Compliance

- Compliance fail point related to internal Medicare procedures.
  - Offer or Provided free services to Medicare patients.
    - Medicare prohibits any actions that would be considered an inducement to a potential or existing patient
  - Medicare prohibits upcoding or downcoding procedures. Correct coding for services performed has to coordinate with the adjustment of medically necessary vertebrae.

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Medicare Compliance

- What can we learn from the DOJ vs. Friendly case?
  - Can not offer or provide free services to Medicare patients including examinations, therapies or treatments.
  - Do NOT include Medicare/ Medicaid patients in any coupons, gift cards or other type of advertising system for new patients.
  - Do not downcode or upcode services.

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Medicare Compliance

- Dr. I. M. Fedup sees a website that promises to show Dr. Fedup a way to "opt out" of Medicare and still be able to see Medicare patients.
- Dr. Fedup is advised to perform the following procedures:
  - State that your practice is a maintenance only practice and require the Medicare patient to check box 2 of the Medicare ABN form.
  - Do not get a Medicare number so you are off the radar
  - Go "cash only"
  - Use the manual therapy codes 97140 to represent the spinal adjustments which is not a covered service under Medicare.

Medicare Compliance

- The false belief that chiropractors can opt out of Medicare-you can't
  - You are either in and following the rules or you are 100% out.
- Can not be "off the radar" and treat Medicare patients for cash
- Can not be a "maintenance" practice and force a patient to sign box 2 of the ABN to be a patient.
- Can not creatively code to have only non-covered services.

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40.4 – Definition of Physician/Practitioner (Rev. 62, Issued: 12-22-06, Effective: 11-13-06, Implementation: 04-02-07) For purposes of this provision, the term "physician" is limited to doctors of medicine; doctors of osteopathy; doctors of dental surgery or of dental medicine; doctors of podiatric medicine; and doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the State in which such function or action is performed; no other physicians may opt out. *Also, for purposes of this provision, the term "practitioner" means any of the following to the extent that they are legally authorized to practice by the State and otherwise meet Medicare requirements: Physician assistant; Nurse practitioner; Clinical nurse specialist; Certified registered nurse anesthetist; Certified nurse midwife; Clinical psychologist; Clinical social worker; Registered dietitian; or Nutrition Professional. The opt out law does not define "physician" to include chiropractors; therefore, they may not opt out of Medicare and provide services under private contract.*

Medicare Compliance

- Case #4: Cloning of Medicare documentation

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Medicare Compliance

- Case #4: Patient A: date of visit 10/14/16
- Subjective: Low back pain. The symptoms are bilateral. With unbearable symptoms reported today. The symptoms are described as dull ache, sharp and tightness. Patient's expectations: become pain free. Patient rates the symptoms at 10. Activity affected level is rated at 10. They symptoms are happening constantly (76-100% of the day). Nothing works to make the symptoms better.

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Medicare Compliance

- Case #4: Patient A: date of visit 11/15/16
- Subjective: Low back pain. The symptoms are bilateral. With unbearable symptoms reported today. The symptoms are described as dull ache, sharp and tightness. Patient's expectations: become pain free. Patient rates the symptoms at 10. Activity affected level is rated at 10. They symptoms are happening constantly (76-100% of the day). Nothing works to make the symptoms better.

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Medicare Compliance

- Compliance fail point:
  - EHR cloning problems
    - Ability to bring data forward in most systems.
      - Bringing the initial examination information forward creates a misconception that the data was produced on that date.
    - Cloning is considered fraud by Medicare

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Medicare Compliance

- Advanced Chiropractic Services OIG report 2015
  - Key issues
    - Coding for services provided
    - Treatment plan

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Medicare Compliance

- Advanced Chiropractic Services OIG report 2015
  - OIG audit
    - Results:
      - All 105 claims were found to be medically unnecessary.
      - ACS did not have adequate policies and procedures to ensure that the medical necessity of chiropractic services billed to Medicare was adequately documented in the medical records.
      - Based on the % denied they wanted all $737,111 back

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What are the rules for documentation?

Medicare Benefits Policy Manual Chapter 15, Section 240

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- "No matter what the "experts" say, you can't modify or interpret the Medicare rules in a way to fit your desired office policies and procedures that result in a system that is detrimental to the Medicare beneficiary or Medicare Trust Fund."
- *-Steven Conway DC, Esq.*

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"You can't 100% macro Medicare Documentation."

- *-Steven Conway DC, Esq.*

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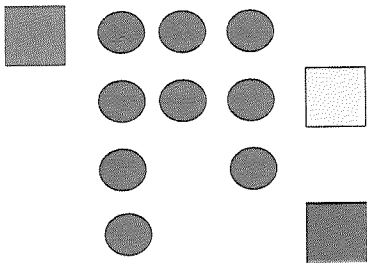
What are they looking for?



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Future Audits will be based on "Episode of Care."

1. Onset date
    1. Provides the start of care date
2. Mechanism of Injury
    1. Defines the type of injury and potential severity level
3. Treatment plan
    1. Provides the estimated:
        1. End date
        2. Number of visits
4. Diagnosis

5. History/ Exam data
6. Subsequent visits and CMT codes for visits.

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3 Phases of a Medicare Case

Beginning Phase:

Initial visit is key to the entire case. Involves identifying the condition and developing the treatment plan.

Middle Phase:

Subsequent visits provide the necessary information to verify the treatment provided to achieve functional improvement.

Ending Phase:

Properly releasing the patient to end the episode of care.

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3 Phases of a Medicare Case

Initial visit:

- Identify the Mechanism of trauma.
- Properly describe the neuromusculoskeletal symptoms.
- Demonstrate the causal relationship of symptoms to a subluxation.
- Create a CORRECT treatment plan.

Subsequent visit:

- History (what subjective changes are happening from last visit. Are you achieving your treatment goals)
- Exam (What physical changes are happening since the last visit)
- Treatment (What did you adjust)

Release:

- Reached maximum functional improvement demonstrated by achievement of treatment plan GOALS.
- ABN provided to patient if patient continues for maintenance treatments.

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Initial Visit Requirements

240.1.3 - Necessity for Treatment
(Rev. 23, Issued: 10-08-04, Effective: 10-01-04, Implementation: 10-04-04)

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam, as described above.

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Initial Visit Requirements

- History
- Description of the present illness
- Evaluation of musculoskeletal/nervous system through physical examination.
- Diagnosis
- Treatment Plan
- Date of the initial treatment

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Initial visit: History

- Symptoms causing the patient to seek treatment
- Family history if relevant
- Past health history
- Mechanism of trauma
- Quality and character of symptoms/problem
- Onset, duration, intensity, frequency, location and radiation of symptoms
- Aggravating or relieving factors
- Prior intervention, treatment, medications and secondary complaints.

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Initial visit: History

- Symptoms causing the patient to seek treatment
- Family history if relevant
- Past health history
- Mechanism of trauma
- Quality and character of symptoms/problem
- Onset, duration, intensity, frequency, location and radiation of symptoms
- Aggravating or relieving factors
- Prior intervention, treatment, medications and secondary complaints.

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Initial visit: History

- Symptoms causing patient to seek treatment
  - Document ALL of the symptoms
  - Symptoms need to be neuromusculoskeletal conditions
  - Symptoms MUST correlate to a specific vertebrae
  - Symptoms will be correlated to your DX and subsequent coding choices for subsequent visits.

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Initial visit: History

- Symptoms causing patient to seek treatment

- **240.1.2 - Subluxation May Be Demonstrated by X-Ray or Physician's Exam**

These symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro) and be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder, and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such. The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited. A statement on a claim that there is "pain" is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

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Initial visit: History

- Mechanism of Trauma
  - Document the cause of the patient's injury
  - Correlate to patient's condition
  - List the specific mechanism of trauma in your notes for each initial onset and any subsequent new injury.
  - Do not simply change area of pain or diagnosis and start a new series of treatment without considering the mechanism of trauma.

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Initial visit: History

- Mechanism of Trauma
  - Trauma does not have to be caused by a patient falling down a flight of stairs.
  - Mechanism of trauma can be:
    - Pick up grandchildren
    - Moved furniture
    - Slept wrong and woke up in pain
    - Care of aging spouse activities
  - Can be related to an accident years ago with a current exacerbation or flare up.

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Initial visit: History

- Mechanism of Trauma
  - What if they can't remember?
    - Only use insidious onset as a last choice
    - Document a series of questions used to elect the potential source of the pain in your notes.
    - DO NOT macro the mechanism of trauma questions. Make them specific to your patients.

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Initial visit: History

- Mechanism of Trauma
  - Assists in developing the treatment plan
  - Coordinate the mechanism of trauma to the DX and duration and frequency sections of the treatment plan.
  - You MUST coordinate the mechanism of trauma to ANY exacerbation to determine if a new onset is required or just a modification to the existing treatment plan is all that is necessary.

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Initial visit: History

- Mechanism of Trauma
  - Type of trauma + level of symptoms + past history = a correct treatment plan development.

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Initial visit: History

- Quality and Character of symptoms
- Onset, duration, intensity, frequency, location and radiation of symptoms.
  - Correlate each symptom with the quantifying factors above.
  - Where applicable, use numeric rating of the quantifying factor!
    - Use VAS/NAS of 3 rather than "mild pain."
  - This process establishes the initial severity of the condition to assist with developing a correct treatment plan.
  - This information will also be useful for setting the GOALS which will define the specific pathway towards the correct END POINT OF CARE.

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Initial visit: History

- Quality and Character of symptoms
- Onset, duration, intensity, frequency, location and radiation of symptoms.
  - Mild, Moderate, severe / better, same, worse / good, gooder, not so good.
  - Use adjectives: Burning, Sharp, Stabbing, Achy
  - Use Pain Scales: Vas/ NAS of 9 on a scale of 0-10.

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Initial visit: History

- Quality and Character of symptoms
- Onset, duration, intensity, frequency, location and radiation of symptoms.
  - Constant, intermittent, continuous, infrequent
  - Use Time Intervals.
    - The use of numbers assists in measuring the level of the symptoms.
  - Constant = 24hrs or only when awake?
- Example: Patient presented with neck pain of insidious onset. She describes her neck pain as severe and constant in nature.

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Initial visit: History

- Example Narrative format
  - On 4/29/18 patient first experienced pain in her lower back region on the left side as a result of spring cleaning her home including moving furniture, vacuuming and washing windows. The pain level is currently noted at 4/10 on the NAS scale. The patient states that the pain a dull ache throughout the day and increases and becomes more sharp when she bends forward. The pain does not radiate into her hips or leg. The pain has decreased her sleep levels from a normal 7 hours a night to 4 hours. She can also only sit for 20 minutes without the need to get up and move around. She was not previously restricted in her ability to sit with out pain.

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Initial visit: History

- Example Bullet point format
  - **Onset:** On 4/29/18 patient first experienced pain in her lower back region on the left side.
  - **Mechanism of Trauma:** The patient was injured as a result of spring cleaning her home including moving furniture, vacuuming and washing windows.
  - **Intensity:** The pain level is currently noted at 4/10 on the NAS scale.
  - **Frequency:** The patient states that the pain a dull ache throughout the day and increases and becomes more sharp when she bends forward.
  - **Location and radiation of symptoms:** The pain does not radiate into her hips or leg.
  - **Affect of injury:** The pain has decreased her sleep levels from a normal 7 hours a night to 4 hours her ability to sit for only 20 minutes.

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Initial visit: History

- Prior interventions, treatments, medications, secondary complaints.
  - Important to get all of the secondary complaints especially for coding purposes.
    - Medicare medically necessary adjustments vs Chiropractic compensatory adjustments.
  - Vertebrae adjusted must be causally related to symptoms to be Medicare medically necessary.
  - Must coordinate DX and symptoms to medically necessary vertebral subluxation adjustments.

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Initial visit: History

- Medically necessary adjustments
  - Coding 98941 and 98942
    - Pain symptoms
    - Causal relationship to Subluxation
    - Technique issues / compensatory subluxations
    - Down or Up coding issues.
    - Down coding is an issue so do NOT code all at 98940

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Initial visit: History

- Prior interventions, treatments, medications, secondary complaints.
  - Is this really an initial visit?
    - Exacerbation or a new condition
    - Documentation of previous chiropractic treatment must be noted in the history.
    - List all medical interventions to assist with the development of the treatment plan.
      - More complex medical conditions can extend the duration of a treatment plan.

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Initial visit: Present illness

- Do NOT macro this section.
- This section will essentially be the chief complaint documentation that you will use in the subsequent visits to demonstrate "changes" in the patient's condition based on the treatment provided.
- Do NOT just put "neck pain." Fully describe the patient's present condition.
- You can take the relevant information from the History section and move it to this section- you don't have to reinvent the wheel, but you need to specifically have this section of the initial visit properly documented in your notes.

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Initial visit: Examination

- Evaluation of the musculoskeletal / nervous system through physical examination.
- The required examination components are similar to other patient examinations.
- Medicare examinations need to identify causally related subluxations to the history pain symptoms
  - P.A.R.T. Analysis to determine subluxation
  - X-ray analysis to determine subluxation
- Keep in mind the goals of determining a functional impairment or a loss of physical functions related to a neuromusculoskeletal component.

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Initial visit: Examination

- Evaluation of the musculoskeletal / nervous system through physical examination. P.A.R.T.
- Allowed chiropractors the ability to use physical examination techniques rather than only x-rays to determine the presence of a subluxation.
  - P: Pain
  - A: Asymmetry
  - R: Range of Motion
  - T: Tissue Tone
- At least 2 of the 4 P.A.R.T. components MUST be determined to be significant and one of the 2 needs to be Asymmetry or Range of Motion.

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Initial visit: Diagnosis

- Initial DX must be a subluxation diagnosis and correlate to the specific vertebral subluxations found in the examination section.
- Must use the M99.01-M99.05 segmental dysfunction codes.
- NMS are used in the secondary DX codes
- Universal agreement and LCD harmonization efforts

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Initial visit: Treatment Plan

- **Treatment Plan**
  - Frequency
  - Duration
  - Specific measurable goals
    - Establish objective targets that can be measured to know if you actually achieved your goals.

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List of commonly used chiropractic goals

- Reduce Pain
- Increase Function
- Increase Range of Motion
- Increase segmental motion and flexibility
- Improve the % noted on Oswestry form

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Resulting chiropractic "Macro"

- Goal of treatment will be to decrease inflammation and pain, increase range of motion, segmental motion and flexibility as well as increasing the quality of life of the patient.
- Improve patient's overall symptoms and complaints noted on Oswestry by 20%

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Initial visit: Treatment Plan Goals

- Specific Goals vs Generic Goals
  - Reduce pain vs achieve a reduction in pain from 8 to 4 on the VAS pain scale rating.
- Use of Meaningful Goals vs "lets see what is worst on the Oswestry form."
  - Use goals that correlate to the mechanism of trauma and patient's symptoms.
  - Goals that can be measured and verify you achieved them.
- Compare to Workers Compensation goals.

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What Goals should I include?

- NO specific goal requirements are listed by Medicare.
- Highly recommend, but NOT required goals include:
  - Activities of Daily Living (ADL) goals
  - Goals associated with Oswestry or other OAT forms.
  - Quantifiable, measurable goals using numbers
    - Pain level
    - Range of motion

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Initial visit: Treatment Plan

- Change the way you determine your treatment plan
  - Current model starts with visit FREQUENCY
    - _____ X a week
  - Then you add in DURATION
    - 3 times a week for _____ weeks.
  - Then you add in a generalized Goal:
    - 3 times a week for 4 weeks to reduce pain and increase function.

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Initial visit: Treatment Plan

- New Model-START WITH THE GOAL FIRST!
  - Initiate the treatment plan process by determining the specific measurable goal.
  - Start with a goal that can be measured.
  - Correlate the goal to the mechanism of trauma.
  - Use ADL and other measurable goals.
    - Decrease VAS from 8 to 3
    - Increase cervical rotation to the right from 25 to 40 degrees
    - Increase ability to sleep from current 2 hours to 6 hours.

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Initial visit: Treatment Plan

- NEXT-Focus on DURATION
  - Determine how long it will take to obtain the specific measurable goals and return the patient to pre-trauma status.
  - There are no limitations set by Medicare for duration
    - Average for acute is 3-4 months
    - Average for chronic can be longer
  - The DURATION decision will create the actual ZONE for the pre-determined release of care (red box)
  - Actual release date may change, but this system will give you and the MACs a predicted ZONE for release.

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Initial visit: Treatment Plan

- NEXT (and last) -Focus on FREQUENCY
  - The only limitation on frequency is "reasonable." The MACs have released the screens and limitations on Frequency.
    - Do not simply chose 12 or 20 visits based on fear or unknown.
  - Simply determine how many visits you will need to achieve the specific measurable goals within the already determined DURATION.
  - Please note that the final frequency determination will be used on all subsequent visit documentation.

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Initial visit: Treatment Plan

- OLD Treatment Plan
  - Patient will be seen 3 times a week for 4 weeks to decrease pain, increase range of motion and segmental function.
- NEW Treatment Plan
  - Specific Measurable goals:
    - Increase ability to sleep without waking up from pain from current 1 hour to previous 5 hours.
    - Decrease low back pain rated at 8 on VAS to 4.
    - Increase lumbar flexion from current 10 degrees to previous 60 degrees.
  - Duration to achieve goals:
    - 1 month.
  - Frequency:
    - 12 visits.

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Initial visit: Treatment Plan

- Compliance
  - The perfect patient
  - The what we see in our office each day patient
    - Exacerbation vs New Onset
      - Modify current TP or create entirely new one
      - Can NOT simply change DX or goals

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Initial visit: Treatment Plan

240.1.5 - Treatment Parameters
(Rev. 23, Issued: 10-08-04, Effective: 10-01-04, Implementation: 10-04-04)

The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time.

Acute subluxation (e.g., strains or sprains) problems may require as many as three months of treatment but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.

Chronic spinal joint condition implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already "set" and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

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Initial visit: Treatment Plan Summary

- Review what was the patient's status prior to the onset to determine what is reasonable status to set for a goal. Goals need to be set to achieve this status, not return them to when they were 18 years old or 100% pain free.
- Review the mechanism of trauma and correlate the goals to the trauma mechanism and specific vertebrae affected.
- Start with ADL goals and make it specific and measurable in a way that you can quantify your progress.
- Add in physical goals, VAS, ROM or others and use Numbers to quantify the starting point and specific desired end point.
- Determine the Duration of the time it will take you to achieve the goals
- Determine the frequency you will need to treat the patient within the established durational timeframe.
- Release the patient when functional goals are met.

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Subsequent Visit

- History:
  - Review of chief complaint
  - CHANGES SINCE LAST VISIT
  - Use VAS information in this section
- Physical Exam
  - Examination of area of spine involved in diagnosis
  - Assessment of change in patient condition since last visit.
  - Evaluation of treatment effectiveness (Functional Goal Improvement)
  - PART is NOT required on each subsequent visit.
- Documentation of treatment given on the day of visit.
  - You are REQUIRED to list the specific vertebrae adjusted.
  - LIST THE VISIT NUMBER COMPARED TO TREATMENT PLAN ESTIMATE. FOR EXAMPLE 7 OF 15

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Subsequent Visit: Key Points

- Primarily considered a therapeutic visit.
  - Importance of each visit is now less with the new emphasis on the "episode of care."
- Always compare to the previous visit.
  - They are monitoring any level of change, but also realize that changes from Monday to Wednesday will not be dramatic.
- Always review and monitor your specific measurable goals on each visit.

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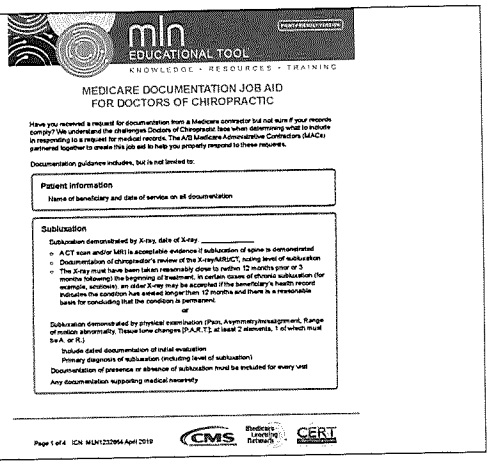

mln EDUCATIONAL TOOL

KNOWLEDGE • RESOURCES • TRAINING

MEDICARE DOCUMENTATION JOB AID
FOR DOCTORS OF CHIROPRACTIC

Have you received a request for documentation from a Medicare contractor but not sure if your records comply? We understand the challenges Doctors of Chiropractic face when determining what to include in responding to a request for medical records. The A/B Medicare Administrative Contractors (MACs) partnered together to create this job aid to help you properly respond to these requests.

Documentation guidance includes, but is not limited to:

Patient information

Name of beneficiary and date of service on all documentation

Subluxation

Subluxation demonstrated by X-ray, date of X-ray _____

- A CT scan and/or MRI is acceptable evidence if subluxation of spine is demonstrated
- Documentation of chiropractor's review of the X-ray/MRI/CT, noting level of subluxation
- The X-ray must have been taken reasonably close to (within 12 months prior or 3 months following) the beginning of treatment, in certain cases of chronic subluxation (for example, scoliosis), an older X-ray may be accepted if the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent

or

Subluxation demonstrated by physical examination (Pain, Asymmetry/misalignment, Range of motion abnormality, Tissue tone changes [P.A.R.T.], at least 2 elements, 1 of which must be A. or R.)

Include dated documentation of initial evaluation

Primary diagnosis of subluxation (including level of subluxation)

Documentation of presence or absence of subluxation must be included for every visit

Any documentation supporting medical necessity

CMS Medicare Learning Network CERT

Initial Evaluation

History
- Date of initial treatment
- Description of present illness
- Symptoms bearing a direct relationship to level of subluxation causing patient to seek treatment
- Family history (if relevant) (recommended)
- Past health history (recommended)
- Mechanism of trauma (recommended)
- Quality and character of symptom/problem (recommended)
- Onset, duration, intensity, frequency, location and radiation of symptoms (recommended)
- Aggravating or relieving factors (recommended)
- Prior interventions, treatments, medication, and secondary complaints (recommended)

Contraindications (e.g., risk of injury to patient from dynamic thrust, desurosis of risk with patient) (recommended)

Physical examination (P.A.R.T.)

Evaluation of musculoskeletal/nervous system through physical examination

Documentation of presence or absence of subluxation must be included for every visit

Treatment given on day of visit (if applicable)
- Include specific areas/levels of spine where manipulation was performed
- Manual devices that are hand-held with the thrust of the force of the device being controlled manually may be covered, however, no additional payment is made nor does Medicare recognize an extra charge for use of the device.

Treatment Plan

Frequency and duration of visits (recommended)

Specific treatment goals (recommended)

Objective measures to evaluate treatment effectiveness (recommended)

Subsequent Visit

History

Review of chief complaint

Changes since last visit

System (if relevant)

Physical examination (P.A.R.T.)

Assessment of change in patient condition since last visit

Evaluation of treatment effectiveness (address objective measures included in treatment plan)

Documentation of presence or absence of subluxation must be included for every visit

Treatment given on day of visit (include specific areas/levels of spine where manipulation was performed)

General Guidelines

Ensure medical records submitted support the service is "corrective treatment," rather than maintenance

- For Medicare purposes, an AT modifier must be placed on a claim when providing active/corrective treatment to treat acute or chronic subluxation
  - Do not use Modifier AT when maintenance therapy has been performed
  - Modifier AT must only be used when chiropractic manipulation is "reasonable and necessary" as defined by national and local policy
  - NOTE: Presence of the AT modifier may not in all instances indicate the service is reasonable and necessary. As always, contractors may deny if appropriate after medical review

  Be aware of these policies along with any local coverage determination in your area to better understand how active/corrective chiropractic services are covered.

Submit records for all dates of service on claim

Documentation shall be legible and complete (including signatures)

Legible signatures/credentials of professionals providing services
- If signatures are missing or illegible, include a completed signature attestation statement
- For illegible signatures, include a signature log
- For electronic health records, include a copy of electronic signature policy and procedures describing how notes and orders are signed and dated. Validating electronic signatures depends on obtaining this information.

Abbreviation key (if applicable)

Any other documentation provider deems necessary to support medical necessity of services billed, as well as documentation specifically requested in the additional documentation request (ADR) letter

Copy of Advance Beneficiary Notice of Noncoverage (if applicable)

NOTE:

Educational References

For additional information regarding documentation and coverage guidelines, refer to the Centers for Medicare & Medicaid Services' (CMS) internet-only manuals (IOMs) for chiropractic services:

- CMS IOM Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 30.2 and 240
- CMS IOM Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 230
- Medicare Learning Network (MLN) Matters® Special Edition articles: Chronic Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits
- MLN Matters®: SE1502 Educational Resources to Assist Chiropractors with Medicare Billing

Disclaimer:

The Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) Medicare Administrative Contractor (MAC) Outreach & Education Task Force developed this document to provide nationally consistent education on topics of interest to health care professionals. The CERT A/B MAC Outreach & Education Task Force is independent from the CMS CERT team and CERT contractors, which are responsible for calculation of the Medicare Fee-for-Service improper payment rate. Visit the CMS CERT webpage to learn about the CERT Program and review CERT Improper Payments Reports.

Medicare Learning Network® Product Disclaimer

Signature:

- Big Deal to Medicare
  - Medicare requires a signature that is either hand written or electronic. NO stamps
- Signature Log
  - If your signature is poor, then include a Signature Log when submitting any requested documentation.
- Signature Attestation
  - Providers can submit an attestation form if required.

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Signatures

- **3.3.2.4 - Signature Requirements**
- For medical review purposes, Medicare requires that services provided/ordered/certified be authenticated by the persons responsible for the care of the beneficiary in accordance with Medicare's policies.
- The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.
- Scribes are not providers of items or services. When a scribe is used by a provider in documenting medical record entries (e.g. progress notes), CMS does not require the scribe to sign/date the documentation. The treating physician's/non-physician practitioner's (NPP's) signature on a note indicates that the physician/NPP affirms the note adequately documents the care provided.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead should make use of the signature authentication process.

Electronic signatures

Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods.

For example, providers need a system and software products that are protected against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws.

Signature log

- Providers will sometimes include a signature log in the documentation they submit that lists the typed or printed name of the author associated with initials or illegible signature.
- The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document.
- Reviewers should encourage providers to list their credentials in the log. However, reviewers shall not deny a claim for a signature log that is missing credentials.
- Reviewers shall consider all submitted signature logs regardless of the date they were created.

Signature Attestation form

- Providers will sometimes include an attestation statement in the documentation they submit.
- In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

The MACs and CERT shall NOT consider attestation statements where there is no associated medical record entry. Reviewers shall NOT consider attestation statements from someone other than the author of the medical record entry in question (even in cases where two individuals are in the same group, one should not sign for the other in medical record entries or attestation statements). Reviewers shall consider all attestations that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date.

Signature attestation form

Signature Attestation Statement

Beneficiary:
Date (s) of Service:

I_____, hereby attest that the medical record entry for above Medicare beneficiary and date of service accurately reflects signatures/notations that I made in my capacity as rendering provider when I treated/diagnosed the above listed beneficiary.

Signature: _____ Date: _____

3.3.2.5 - Amendments, Corrections and Delayed Entries in Medical Documentation

(Rev. 732; Issued: 07-21-17; Effective: 08-22-17; Implementation: 08-22- 17)

A. Amendments, Corrections and Delayed Entries in Medical Documentation

All services provided to beneficiaries are expected to be documented in the medical record at the time they are rendered.

Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended, corrected, or entered after rendering the service.

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MACs, CERT, Recovery Auditors, SMRC and ZPICs containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or delayed entry as such, and
2. Clearly indicate the date and author of any amendment, correction or delayed entry, and
3. Clearly identify all original content, without deletion.

Paper Medical Records: When correcting a paper medical record, these principles are generally accomplished by:

1. Using a single line strike through so the original content is still readable, and
2. The author of the alteration must sign and date the revision.

Amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record. Amendments or delayed entries to paper records may be initialed and dated if the medical record contains evidence associating the provider's initials with their name. For example, if the initials match the first and last name of the practitioner documented elsewhere in the medical records including typed or written identifying information, the reviewer shall accept the entry.

Electronic Health Records (EHR): Medical record keeping within an EHR deserves special considerations; however, the principles specified above remain fundamental and necessary for document submission to MACs, CERT, Recovery Auditors, SMRC and ZPICs. Records sourced from electronic systems containing amendments, corrections or delayed entries must:

a. Distinctly identify any amendment, correction or delayed entry, and

b. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

C. If the MACs, CERT, SMRC or Recovery Auditors identify medical documentation with potentially fraudulent entries, the reviewers shall refer the cases to the ZPIC and may consider referring to the RO and State Agency.

ABN: Advanced Beneficiary Notice

- Mandatory for Covered Services
- Voluntary for non-covered services
- Specific times to provide ABN
  - AT to Maintenance
  - Good for 1 year or a new onset date occurrence
- CAN NOT be used routinely on first visit to require a patient to be "maintenance."
  - BOX 2 issue
- ATGA

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ABN

Issuing a Voluntary Advance Written Notice of Noncoverage as a Courtesy

You are not required to notify the beneficiary before you furnish an item or service Medicare never covers or is not a Medicare benefit. However, as a courtesy, you may issue a voluntary notice to alert the beneficiary about their financial liability. Issuing the notice voluntarily has no effect on financial liability, and the beneficiary is not required to check an option box or sign and date the notice.

ICN 006266 October 2018

Do not use an advance written notice of noncoverage for items and services you furnish under Medicare Advantage (Part C) You are not required to notify the beneficiary before you furnish items or services that are not a Medicare benefit or that Medicare never covers, such as: • Services when there is no legal obligation to pay

ABN

Other Prohibitions

You cannot issue an advance written notice of noncoverage to:

- • Shift liability and bill the beneficiary for the services denied due to a Medically Unlikely Edit (MUE).
- • A beneficiary in a medical emergency or under great duress (compelling or coercive circumstances). Advance written notice of noncoverage use in the emergency room or during ambulance transports may be appropriate in some cases (for example, a beneficiary who is medically stable and not under duress).
- • Charge a beneficiary for a component of a service when Medicare makes full payment through a bundled payment.
- • Transfer liability to the beneficiary when Medicare would otherwise pay for items and services.

ABN

Beneficiary Refusal to Choose an Option or Sign the Advance Written Notice of Noncoverage

If the beneficiary or the beneficiary's representative refuses to choose an option or sign the notice, you should annotate the original copy indicating the refusal to choose an option or sign the notice.

You may list any witnesses to the refusal, although a witness is not required.

If a beneficiary refuses to sign a properly issued notice, consider not furnishing the item or service unless the consequences (health and safety of the beneficiary or civil liability in case of harm) prevent this option.

ABN

When the Beneficiary Changes Their Mind

If the beneficiary changes their mind after completing and signing the notice, you should request they annotate the completed notice.

They must sign and date the annotation and include a clear indication of their new option selection.

If you cannot provide the notice in person, you may annotate the form to reflect the beneficiary's new option selection and immediately forward a copy to the beneficiary to sign, date, and return.

You must provide a copy of the annotated notice to the beneficiary as soon as possible.

Opt out

- Currently Chiropractors can not Opt Out of the Medicare system.
  - If you want to treat Medicare patients you need to be in the system and follow the rules.
- Can NOT:
  - Alter ABN and have sign on t he first visit for maintenance unless it is actually for maintenance.
  - Just have the patient pay cash and be off the radar
  - Not register for Medicare and just treat patients for "non-covered services."
    - Manual therapy vs CMT
  - Not bill for CMT services.

Contact information

- Steven Conway DC, Esq.
- ChiroArmor.com
- chirolaw@aol.com
- DrC@chiroarmor.com
- 888 892 9299
- 727 421 0407 personal cell

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Key points for any audit response

Do not alter your documentation (it is what it is)

Do not make a "new story" with additional documentation.

Make sure you provide all documentation to support your AT decision.

Make sure each entry has a Signature

Log / attestation page

Levels of severity

Carrier denials

CERT review Comprehensive Error Rate Testing program

Probe review

RAC audits (bounty hunters) Recovery Audit Contractors

ZPIC audit Zone Program Integrity Contractor

OIG audit /onsite(chat) Office of Inspector General

CERT review

CERT Process

A random sample of claims submitted in a specific calendar year are selected

Requests for medical records from providers for claims in the sample.

Next the claims and medical records are reviewed to see if they comply with the Medicare coverage, coding and billing rules.

If errors are found, money is recouped from providers. This can happen when:

Providers don't submit any documentation.

Providers submit insufficient documentation.

The medical record submitted indicates that the service was not medically necessary, was incorrectly coded, or was not in compliance with some other Medicare rule.

CERT request

- What to Do if You Receive a CERT Request for Record?

  These reviews are very important, not only for the individual doctor, but for the chiropractic profession as a whole.

For each request on date(s) of service (DOS), you will want to make sure that you:

Send in the notes for that DOS

Send in all related information—including:

a. the most recent exam,
b. full history,
c. treatment plan, and
d. any diagnostic findings.

All of these items help a reviewer place the pertinent DOS in a larger context.

CERT Summary

- It is important to note that these reviews are random in nature and assist CMS in obtaining an overall view of how various groups are performing including: the carriers, regions of the country, services, professions, etc.
- CERT reviews are independent of Medicare carriers/ MACs.
- Doctors must respond promptly to CERT requests for records. Your letter from CERT will indicate the timeframe within which you need to respond. Most often providers have 75 days to respond. For CERT special studies, providers are only given 30 days to respond.
- If you disagree with your CERT findings, you are given the opportunity to appeal.

Levels of severity

Carrier denials

CERT review Comprehensive Error Rate Testing program

Probe review

RAC audits (bounty hunters) Recovery Audit Contractors

ZPIC audit Zone Program Integrity Contractor

OIG audit /onsite(chat) Office of Inspector General

Probe review

- Medical Review Progressive Corrective Action (PCA) process
  - PCA is used to identify potential problem areas and implement the processes performed by Medical Review. This is a comprehensive term that includes the following:
    - Data Analysis
    - Medical review of claims
    - Education of providers on the requirements for payment under the Medicare program

Probe review

- **Data Analysis**
  - Data analysis is the first step in the PCA process. It includes reviewing claim submissions locally, regionally and nationally for atypical patterns/ trends that may indicate a potential problem.
  - 98941-42 codes
  - Monthly treatment patterns
  - Patterns of DX changes with TX

Probe review

- There are 2 types of probe reviews:
  - Service specific
    - usually include a 100 claim sample based on a specific service (procedure code, diagnosis, HCPCS)
    - The claims are selected randomly from providers billing the service in question.

Probe review

- There are 2 types of probe reviews:
  - Provider specific
    - Usually includes 20-40 claims samples based on claims from the selected provider.
    - The sample of claims selected will be based on the nature of the review (specific service or various services billed by the selected provider)

Probe review

- Provider specific probe review:
  - Once a claim has been selected for review, documentation is requested from the provider billing the service.
  - This request is referred to as an Additional Documentation Request (ADR) letter.
  - Copies of the requested medical records must be submitted within 30 days of the date on the ADR.
  - Failure to submit the requested documentation will result in a denial of all charges on the claim.
  - Once the appropriate number of claims have been reviewed and processed, a charge denial rate (CDR) is calculated.

Probe review

- The CDR is determined by dividing the total charges for the claims reviewed and processed into the total denied charges for the claims reviewed and processed. The results are multiplied by 100 and reported as a percentage.
  - This calculation is used to determine the following:
    - The percentage of charges that have been billed in error
    - The extent this error is occurring
    - Guidance to direct additional activities that may be initiated as a result of the findings. Based on the review, several actions may occur such as:
      - no further action necessary
      - Provider notification and feedback
      - Additional medical review (TR targeted review program)
      - Request for overpayment of denied claims
      - Referral to additional governmental agencies

Probe review response

- Provide all documentation associated with the request.
- Attach a copy of the ADR to your response. The ADR contains the address of the Medical Review department.
  - If mis-routed can result in 100% denial due to untimely response.
- Cover letter outlining the case

Probe review response

- Do not alter your documentation (it is what it is)
- Make sure you provide all documentation to support your AT decision.
- Do not make a "new story" with additional documentation.
- Make sure each entry has a Signature
  - Log / attestation page

What can happen at end of probe review

- Case is closed
- Provider education recommended
- **Request for overpayment (appeal process)**
- **Referral for TR**
- Referral to ZPIC
- Referral to law enforcement

Probe review summary

- Carrier selects claims from a specific provider who has been identified as having a potential problem identified through their billing patterns
- The provider is notified in writing that a probe review (sample of 20-40 claims) is being conducted.
- Response must contain documentation necessary to support the level of service and medical necessity of services rendered.
- 30 days to respond to request for documentation. Anything missing the deadline will be not considered in the review
- They are required to recover funds for any overpayment based on denials of claims.
- Appeal of denial and request for overpayment is performed through the 5 stage Medicare appeal process.

Levels of severity

Carrier denials

CERT review Comprehensive Error Rate Testing program

Probe review

RAC audits (bounty hunters) Recovery Audit Contractors

ZPIC audit Zone Program Integrity Contractor

OIG audit /onsite(chat) Office of Inspector General

RAC Summary

- Scare tactics in the DC media
- They need to get CMS approval first
- Problem that they get % so less likely to be fair minded in review process.
- Do not face a RAC on your own...

Levels of severity

Carrier denials

CERT review Comprehensive Error Rate Testing program

Probe review

RAC audits (bounty hunters) Recovery Audit Contractors

ZPIC audit Zone Program Integrity Contractor

OIG audit /onsite(chat) Office of Inspector General

ZPIC Audits

- Designated to determine Medicare Fraud, waste or abuse
  - Fraud frequently arises from false statements or misrepresentations made that are material to entitlement or payment under the Medicare Program.

  Audits prompted by data research related to irregular billing patterns.
- Current ZPICs involve requests from AdvanceMed
  - Self audits
    - Concept of self audit is new
    - One has CD requesting specific information, but refuses to accept or review your notes

OIG Audits

- Onsite review
  - Initial meeting in your office.
    - Obtain all records.
    - Review process with you
    - Create report that is will be published and available on the internet.
    - Ability to respond
- Demand letter will arrive from carrier

OIG Audits

- Paper review
  - Will receive a notice from OIG
  - Request will be for specific patients and dates of service
  - Must respond
    - Cover letter
    - Include all documentation supporting the dates of service

Key Points to prevent audits

Common errors they are finding during medical reviews:

- Missing patient names or dates of service
- Missing signatures
- Illegible documents
- Insufficient or absent documentation
  - Elements of history and exam are missing
  - PART examinations were not met
    - PART needed for each spinal level adjusted
    - Treatment plan absent or insufficient

Key Points

Common errors continued:

- Subsequent visits do not show progress towards objective goals.
  - "Increase in ROM or decrease in Pain do not cover it anymore"
- No Key provided if unapproved abbreviations are used (travel cards)
- No documentation to support or substantiate procedures were performed
  - No documentation that ALL spinal levels manipulated **exist** via PART examination.
  - Missing symptoms relevant to EACH LEVEL OF ADJUSTMENT.
- EHR records are being CLONED and as a result are invalid.

5 levels of appeal

- Redetermination
- Reconsideration
- ALJ
- MAC
- District Court

Initial determination
(the first denial)

- 42 CFR section 405.920-.928: The initial determination notice sent to providers must contain:
  - The basis for any full or partial denial
  - Information regarding the right to a redetermination if dissatisfied with the initial determination
  - All applicable claim adjustment reasons and remark codes explaining the initial determination
  - The source of the remittance advice and who may be contacted for further information

Redetermination
42 CFR section 405.940-.958

- Recoupment process is turned ON
- Redetermination request must be filed within 120 days from receipt of notice of initial determination. There is no amount in controversy requirement.
- The request must contain an explanation of the basis for disagreement with the contractor's determination and should include any applicable evidence.
- Response from the carrier must be within 60 days of receiving the redetermination request.

Redetermination
42 CFR section 405.940-.958

- **Response must include:**
  - a clear statement indicating why you disagree with the carrier's unfavorable initial determination
  - Summary of the facts
    - Contradict their reasons for denial with facts NOT emotion....
  - Explanation of how applicable law, regulations and policies apply to the facts
  - A summary of the rationale for the redetermination (your summary points)
  - Request to turn off recoupment process

Redetermination Summary

- Filing a Response (what to include)
  - Medicare redetermination form
  - Cover letter outlining disagreement with the initial determination
  - Facts or information that supports your position
  - Medical records
  - Expert reports
  - Request to turn off recoupment process

Redetermination

- Strategy:
  - Make sure you provide ALL of your evidence to support your position. Don't hold back.
  - Use of Legal and expert resources

Reconsideration

- **You have 180 days to respond to the redetermination denial.**
- **Response must include:**
  - a clear statement indicating why you disagree with the carrier's unfavorable redetermination response
  - Summary of the facts
    - Contradict their reasons for denial with facts NOT emotion....
  - Explanation of how applicable law, regulations and policies apply to the facts
  - A summary of the rationale for the reconsideration appeal (your summary points)
  - Request to turn off recoupment process
  - All previous information sent will be forwarded to the QIC. You just have to send in any new information.

Reconsideration

- Strategy:
  - You need to shift from just responding to the single reason for denial found on the initial determination such as missing a signature or no treatment plan to documenting why the care provided was classified as AT and not maintenance.....
  - Make sure you provide ALL of your evidence to support your position on why the care was not maintenance care. Don't hold back.
  - Can not bring in any new evidence after this point.
  - Need to tell the entire story of the single claim being denied
    - Initial date with correct information including examination findings
    - Treatment plan with specific goals are key factors.
  - Use of Legal and expert resources

Reconsideration

- Strategy
  - Inclusion of cover letter
  - Inclusion of information from the initial date related to the denied date.
  - Inclusion of information related to treatment plans and specific measurable goals that were being monitored and obtained
  - Inclusion of any dismissal date to show that measured goals were obtained.
  - Basically all information to show why this date of service was not maintenance.

Reconsideration Summary

- Filing a Response (what to include)
  - Medicare reconsideration form
  - Cover letter outlining disagreement with the redetermination
  - Facts or information that supports your position
  - Any new Medical records
  - Expert reports are optional at reconsideration, but very helpful at the ALJ level.
  - Request to turn off recoupment process

ALJ

- Administrative Law Judge (ALJ)
- This is where we are winning!!!!
- The reconsideration denials must be submitted within [redacted] days to the ALJ.
- There is an amount in controversy that is required to appeal to the ALJ.
  - Currently it is $140.00
- The ALJ has 90 days to return a decision

ALJ

- ALJ are based on live interaction with a Judge.
  - Conducted at specific sites in the US
    - Cleveland, Miami, LA, etc
    - Can be in person or video teleconference or by telephone.
    - The rules require video teleconference if available
    - In-person requests must be in writing

ALJ

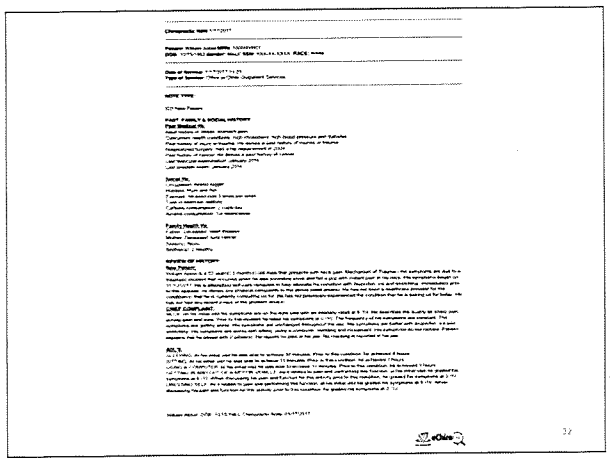
- Filing a Response (what to include)
  - Medicare Request for ALJ form
  - Depending on case, this is where you are best to have an attorney and experts help you.
    - Attorneys will prepare a brief summarizing the case
    - Attorneys will guide the ALJ to the best solution for you
    - Expert Stat and Medical record summaries are also advantageous at this level.
  - Cover letter outlining disagreement with the initial determination and any new disagreements with the redetermination and QIC (reconsideration denial)
  - Facts or information that supports your position
  - Medical records
  - Medical record summary sheet

MAC

- 42 CFR section 405.1100-.1134
- MAC's are part of the Department of Appeals Board of HHS.
- Must appeal ALJ within 60 days of receipt of notice of determination
- Appellants must specify the portions of the ALJ action with which the party disagrees and explain the reasons for the dispute.
- The MAC limits its review to the exceptions raised by the party
- MAC reviews are de novo (looking at it newly and not bound by previous decisions)
- MACs are primarily paper review and require legal briefs or other written statements by the parties. If there is an important question related to the review, the MAC may allow oral arguments.
- The MAC must return a response within 60 days

District Court

- Final stage of review
- 42 CFR section 405.1136-.1140
- Must file action in District Court within 60 days of MAC notice of denial
- New amount in controversy is over $1000.00



TREATMENT PLAN

CMT Contraindications.

Patient declined to have the chiropractic physical examination (CMT).

Goals.

SHORT TERM: The patient specific goal is to attain his pre-accident status of 0 (zero).
LONG TERM: The patient specific goal is to attain his pre-accident status of 0 (zero).
PAIN SCALE: 0 = no pain, 10 = worst pain imaginable. The patient rates his pain on initial visit as 7 (seven). His pain level is 0 (zero) pain.
LIMITING ACTIVITY OF DAILY LIVING (ADL): Activities limiting pain and function. His patient specific goal is to attain his pre-accident status of 0 (zero). His pain is 0 (zero) pain.
RESULTS: The patient's specific goal for his symptoms, is to return his pre-accident status of 0 (zero).
MAINTENANCE: The patient feels his goal has been met, or is to attain his pre-accident status of 0 (zero).

Frequency and Duration of Care.

Treatment of care is estimated to be 6-12 weeks. Post this date of active treatment, it is estimated that the patient will need a total of 24 visits to maintain their condition. It is the initial chiropractor and all therapists to care. The discovery is not minimized or 3 of follow-up visits. A chiropractor should not prescribe appropriate for 3 years, to chiropractic physician, and further courses of care.

Compounding Factors Not Presented Previously.

Pre-surgery scans or x-rays: shown prior
Has had 3 recorded accidents: accidental
Has suffers from a previously surrounding of degenerative joint disease of cervical spine and osteoporosis disc disease or disc hernia or spine

Chiropractic Plan.

Radiographic views authorized in office: NAPC / CTS, AVN-M

X-rays were viewed prior to administering treatment

In Office Treatment.

CHIROPRACTIC MANIPULATIVE TREATMENT (CMT) - CMT is a non-pharmacological response to enhance pain and improve physical function. The treatment must be administered by using a variety of techniques. CMT practices fostering to reducing hypothesis, reducing sub-tissue, removing adhesions, reducing inflammation, promoting interphalangeal joint function and promoting neurological organization, etc.
Treatment CPT: # 98940 (1-2 regions), strength, endurance, range of motion and/or flexibility.
CMT: The patient received chiropractic adjustment. The manipulative objective was to restore optimal joint play and joint motion.
ELECTRICAL MUSCLE STIMULATION - electrical muscle load. Attitude: hydrotherapy, decreases circulation, pain increase, tonic/ flaccid muscle, and hydrotherapy, decreases the formation of adhesions, & atrophy, and prevents forming if removed to the affected region.

Informed Consent.

Informed consent discussion was completed with patient today. Risks, benefits and alternatives of the proposed care were discussed in this file. The following information was discussed and explained in the patient form: presenting condition, diagnosis, and proposed treatment consisting of manual and/or manipulative treatment, physiotherapy, modalities and other therapeutic procedures. The relevant risks and benefits of the proposed treatment program including numbness, stiff tissue injuries, rib injury, stroke, physiotherapy modalities such as used as alternative treatment, pain patterns or not recovering any treatment were reviewed. The patient is competent and has understood all aspects of the risks and benefits related to chiropractic treatments and was voluntary consented to start the recommended treatment and studies.

TREATMENT PROVIDED:

Chiropractic Manipulative Treatment.

Chiropractic Manipulative treatment 1-2 regions performed to the noted vertebrae levels.
Cervical/Occiput: Counterclockwise
Thoracic: Counterclockwise

Chiropractic Manipulative Treatment was shown as manual manipulation was directed to thoracic subluxations of the spine at the following spinal levels:
Cervical: C1 C2 C3 and C4
Thoracic: T4 T5 and T6

Patient Name: [redacted] DOB: 10/05/1961 Chiropractic Note: 11/17/2011

Chiropractic Note 12/1/2017

Patient: Adam Allred **DOB:** 10/05/1961
Date: 12/1/2017 **Gender:** Male **Time:** 4:45:49 AM **PAGE:** 4/4

Date of Service: 12/1/2017 11:30
Type of Service: Office or Other Outpatient Network

NOTE TYPE

SOAP Subsequent Visit Note

SUBSEQUENT VISIT NOTE
HISTORY
REVIEW OF DAILY COMPLAINT:
NECK: Today the symptoms are on the right side with an intensity rated at 5 / 10. His symptoms were described as stiff and sore. Last visit his symptoms were on the right side with an intensity rated at 7 / 10. The patient specific goal for his symptoms is to attain his pre-accident status of 0 / 10. His symptoms are better with stretching.

SELF CARE REVIEW:
He is using 2 times per day. He is stretching 2 times per day.

PHYSICAL EXAM
SPINE EXAM:
Palpation: Palpation: articulation subluxations complaint is confined at the following spinal levels:
Cervical: C1 C2 and C3.
Thoracic: T4 T5 and T6

Tenderness was noted at
C7 on the right. Today it is graded at 1 / 10. Last visit was graded at 1 / 10.

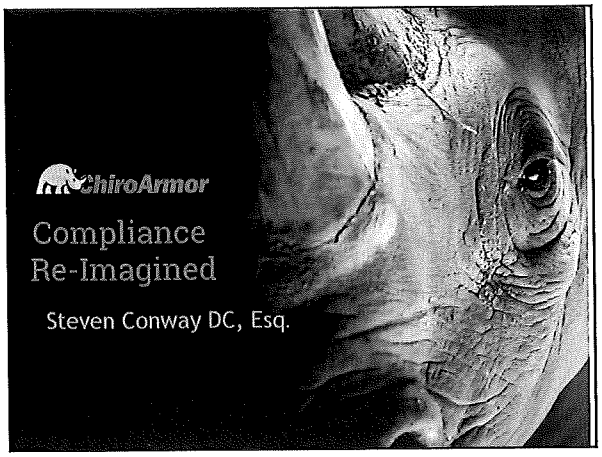
Range of motion was impaired at
C7 on the right. Today it is graded at 1 / 10. Last visit was graded at 2 / 10.

CHIROPRACTIC ACTIVE RANGE OF MOTION:
Flexion: at the side and the cervical spine flexion was 30 /50. Today the flexion is same flexion is 40 /50 with pain and muscle tech on the right in the cervical, thoracic and muscular areas.
Extension: at the side and the cervical spine extension was 30 /50. Today the extension is same extension is 40 /50 with pain and restriction on the right in the cervical, thoracic and muscular areas.

TREATMENT EFFECTIVENESS:
NECK: At the initial visit he was able to complete 5 minutes. Today he is able to complete 20 minutes. At his last visit he was able to complete 10 minutes. The patient specific goal is to attain his pre-accident status of 0 (zero).
DAILY ACTIVITIES: At the initial visit he was able to complete 10 minutes. Today he is able to complete 20 minutes. At his last visit he was able to complete 20 minutes. The patient specific goal is to attain his pre-accident status of 0 (zero).
LIMITING ACTIVITY OF DAILY LIVING (ADL): As it relates to pain and performing this function at the initial visit he graded his symptoms at 7 / 10. Today when presented his pain with the activity, he presents pain at 5 / 10. At his last visit, he showed his pain at 7 / 10. The pain is 0 (zero) pain.

THE TREATMENT PROVIDED
Chiropractic Manipulative Treatment.
Chiropractic manipulative treatment 1-2 regions performed to the noted spinal levels.
Cervical/Occiput: Counterclockwise
Thoracic: Counterclockwise

Patient Name: [redacted] DOB: 10/05/1961 Chiropractic Note: 11/17/2011



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Medical documentationErrors Agenda

- Most common Chiropractic errors
- Understanding informed consent
- Case review Stroke
- Case review low back
- Medical errors and common side effects

2

Where/what is the Primary source of Chiropractic Errors?

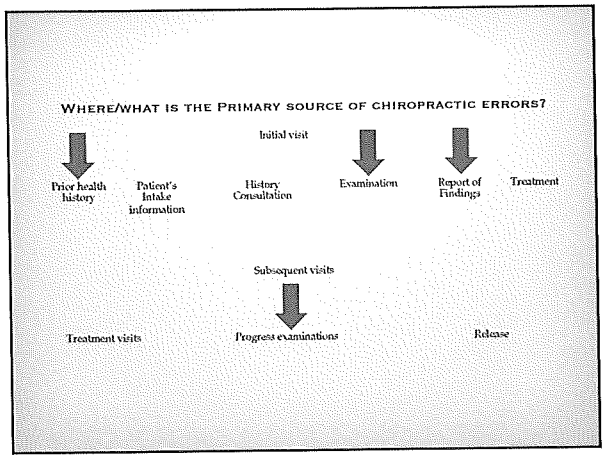
Initial visit

Prior health history | Patient's Intake information | History Consultation | Examination | Report of Findings | Treatment

Subsequent visits

Treatment visits | Progress examinations | Release

3



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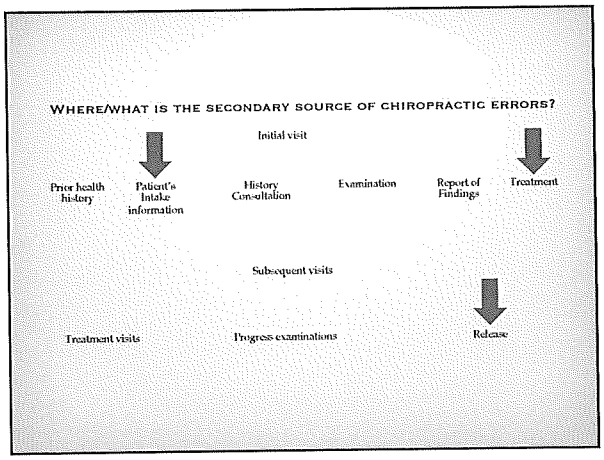

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REVIEWING MALPRACTICE CLAIMS

- Informed consent is a key issue
  - Intake form system
  - Fulfilling all requirements
  - If I would have been properly informed, I would never have consented to treatment.
- Lack of prior history documentation in the file
  - No review of prior history before treatment
  - Past history provided by the patient may be filtered
    - Fear of disclosure would increase financial costs for examinations / diagnostics

6

MALPRACTICE CASE REVIEW

- Examination / Diagnosis
  - Failure to correctly examine/ diagnosis (low back case today)
  - 20/20 hindsight is easy to find errors in documentation
  - X-ray issue / ACA guidelines
- Documentation
  - Poor documentation is difficult to overcome
  - Cloning issues
- Progress Examinations
  - Lack of progress examinations makes it harder to defend continued treatment

7

MALPRACTICE CLAIM REVIEW

- Release
  - Treatment plans that have specific goals/ objectives are key to defending the case
- The "returning patient" vs the "brand new shiny patient"
  - Procedures / Processing
  - History / Examination decisions
  - Informed consent issues

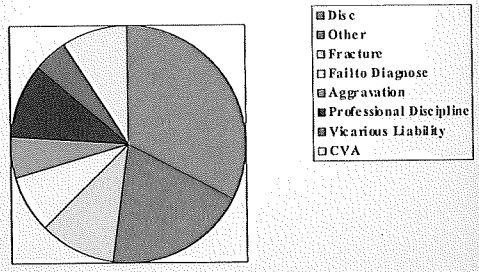
8

FREQUENCY OF CLOSED CHIROPRACTIC MALPRACTICE CLAIMS

Disc Problems	26.7 %
Fracture	13.8 %
Failure to Diagnose	13.1 %
Aggravation of Condition	7.1 %
Cerebrovascular Accidents	5.4 %
Burn	3.4 %
Therapy	3.0 %

9

Types of Chiropractic Claims



10

Common Chiropractic Errors

- **Failure to diagnose and refer**
  fractures, pathology, arterial occlusions
- **Equipment related issues**
  improper equipment maintenance, contraindicated therapy choices, improper supervision of minors in treatment rooms, improper patient/equipment supervision

11

Common Chiropractic Errors

- **Improper treatment**
  high velocity techniques, contraindicated therapies, contraindications to adjustments
- **Erroneous recommendations**
  contraindicated recommendations with regard to medicines / supplements and or treatment including exercise, referrals and recommendations

12

Do you currently have valid informed consent?

- History of informed consent
- Definition of informed consent
- Do you have a valid informed consent?
  - Elements of valid informed consent

13

Quick questions?

- Is a signed intake form a valid informed consent?
- Are you required to disclose stroke information during your informed consent?
- Do you know what is the "reasonable standard" for your state?
- Do you only need to do an informed consent once when they are a new patient?

14

• Sard v Hardy (1977)

- A patient became pregnant despite a tubal ligation procedure.
- The patient claimed the doctor was negligent in failing to advise her that the procedure had a 2% failure rate and that there were alternative methods for sterilization and birth control.
- Court of Appeals agreed with her and established the physician's duty to obtain a patient's informed consent prior to providing any particular treatment
- This duty was held to be separate and distinct from the tort of battery (unpermitted touching or act on a patient) and from negligence in the selection or administration of any particular treatment.

15

SARD V HARDY

- There was no breach in the standard of care provided to the patient. The recommendation was reasonable and the procedures were carefully performed.
- *However, there was a breach of the separate duty to obtain the patient's informed consent* to the procedures as she was not informed of all of the alternatives or risks.
- The rationale is so that a physician does not substitute their judgement, no matter how appropriate, for that of the patient.

16

SARD V HARDY

- The court held the following were required for informed consent:
  - 1. the nature of the patient's ailment or diagnosis
  - 2. the nature of the proposed treatment
  - 3. the probability of success and material risk, complications and outcomes
  - 4. alternatives

17

MCQUITTY V SPANGLER (2009)

- Case involved a patient who gave birth to a child who sustained substantial neurological damage during gestation.
- The patient claimed the doctor did not provide sufficient information to permit her to have informed consent as to whether to continue carrying the child closer to term or to have a sooner Cesarean delivery.
- The Doctor defense was that since he had the *patient's initial informed consent* to continue to carry the child and never proposed a Cesarean delivery, *he had no duty to obtain her informed consent to that procedure.*

18

McQuitty v Spangler (2009)

- The Court agreed with the patient which amplified the informed consent laws. A doctor now has the duty to inform the patient of risks and available alternative treatments related to all material changes in their condition.
- Informed consent now requires provisions of all information material to a patient in determining their course of care. The information must be sufficient to permit the patient involvement in the healthcare choices and treatment alternatives pertinent to their condition.

19

Informed Consent

- When do you need to ask for consent?
  - Consultation
  - Examination
    - Ortho/ Neuro tests? (every tests?)
    - X-ray?
    - Invasive diagnostics
  - Before treatment
    - Same day treatment procedures
  - One and done?

20

Hannemann Case

- Hannemann-the patient, filed a complaint against Boyson in Outagamie County Circuit Court, alleging that the defendant negligently provided chiropractic treatment to the plaintiff,
- Gary Hannemann, as a proximate consequence to which the plaintiff suffered serious and permanent injury. " As stated with more particularity in his scheduling conference statement, Hannemann alleged that "[t]he defendant negligently adjusted the plaintiff's cervical spine resulting in the plaintiff suffering a stroke with permanent disability."

21

HANNEMANN CASE

- During voir dire, Hannemann's attorney began arguing the theory that Boyson failed to provide informed consent by asking the potential jurors if they thought it was wrong for a doctor not to warn a patient about the possibility of harm before performing a procedure, even if "it's a very remote risk" that may result in serious injury or death.
- During opening statements, Hannemann's attorney concentrated on Boyson's alleged failure to discuss the risks inherent in performing a cervical adjustment with Hannemann and his failure to perform appropriate tests on Hannemann.

22

PLAINTIFF ARGUMENT

- **What did the doctor not do?**
  - He didn't recognize the problem and he did not inform on that Saturday morning,
  - He did not inform Gary Hannemann of the risk that he was about to confront with another adjustment.
  - He did not tell him, Gary it's a known fact that there is an association between cervical adjustment and people who have strokes.
  - He did not tell him you had developed very strange neurological symptoms that may indicate that you're in the process of having a neurovascular injury.
  - He did not tell him there are options, maybe you should go to a medical doctor, maybe we should do nothing.

What he did is he decided to proceed with an adjustment, that is exactly what he did. He didn't talk to Gary about the risks. He didn't do a complete neurological and orthopedic exam. He didn't tell Gary to get medical help.

23

FINAL DECISION

- A chiropractor has the duty to provide his patient with information necessary to enable the patient to make an informed decision about a procedure and alternative choices of treatments. If the chiropractor fails to perform this duty, he is negligent.
- To meet this duty to inform his patient, the chiropractor must provide his patient with the information a reasonable person in the patient's position would regard as significant when deciding to accept or reject the medical treatment.
- In answering this question, you should determine what a reasonable person in the patient's position would want to know in consenting to or rejecting a chiropractic treatment.

However, the chiropractor's duty to inform does not require disclosure of: Information beyond what a reasonably, well-qualified chiropractor in a similar classification would know; Extremely remote possibilities that might falsely or detrimentally alarm the patient.

24

- ANALYSIS
  - **Although liability for failure to obtain informed consent is premised on negligence principles, it is nonetheless treated under the law as a separate and distinct form of malpractice: "A failure to diagnose is one form of medical malpractice. A failure to obtain informed consent is another discrete form of malpractice, requiring a consideration of additional and different factors."**
  - **"[T]he touchstone of the test [for informed consent] [i]s what the reasonable person in the position of the patient would want to know."**

25

- ANALYSIS
  - **We reject Hannemann's repeated assertions that informed consent in chiropractic is merely a one-time obligation that is satisfied by simply providing a form before beginning treatment.**
  - ***The form may be evidence or documentation of the risks disclosed to a patient, but the form itself is not informed consent.***
  - Informed consent is "mak[ing] such disclosures as will enable a reasonable person under the circumstances confronting the patient to exercise the patient's right to consent to, or to refuse the procedure proposed or to request an alternative treatment or method of diagnosis."
  - In other words, informed consent is a duty to "make such disclosures as appear reasonably necessary under circumstances then existing to enable a reasonable person under the same or similar circumstances confronting the patient at the time of disclosure to intelligently exercise his right to consent or to refuse the treatment or procedure proposed."
  - Although the specifics of the disclosures will undoubtedly vary between the practice of medicine and the practice of chiropractic, the rules governing the scope and limits of the duty to disclose and obtain informed consent should be the same. The scope and limits of the duty to disclose material risks and obtain informed consent are aptly set forth in Wis JI-Civil 1023.1. While this instruction may need to be modified when applied to chiropractors, this can easily be accomplished.

26

CONCLUSION

- In sum, we conclude that a chiropractor's duty of informed consent is to "make such disclosures as will enable a reasonable person under the circumstances confronting the patient to exercise the patient's right to consent to, or to refuse the procedure proposed or to request an alternative treatment or method of diagnosis."
- He must "make such disclosures as appear reasonably necessary under circumstances then existing to enable a reasonable person under the same or similar circumstances confronting the patient at the time of disclosure to intelligently exercise his right to consent or to refuse the treatment or procedure proposed."

27

CONCLUSION

- We conclude that although the practice of chiropractic and the practice of medicine are distinct health care professions, the obligation of the practitioners of both to disclose the risks of the treatment and care they provide should be the same.
- While the actual disclosures will inevitably vary between doctors and chiropractors, the nature of the duty and limitations thereon should be the same. **A patient of chiropractic has the same right as a patient of medical practice to be informed of the material risks of the proposed treatment or procedure so that he may make an informed decision whether to consent to the procedure or treatment. As such, we hold that the scope of a chiropractor's duty to obtain informed consent is the same as that of a medical doctor.**

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MALPRACTICE / INFORMED CONSENT

- 2 separate charges
- Malpractice difficult to win for plaintiff
- Informed consent became much easier to win

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INFORMED CONSENT CASE

- Chiropractor, Dr. O.K. first met patient A who presented with symptoms of chronic low back pain that was recently acute.
- Patient was in her first trimester of pregnancy.
- Dr. K did not take x-rays or MRI due to pregnancy, but through examination did diagnosis a disc problem.
- Dr K did not have a normal policy to provide a written informed consent form.

30

INFORMED CONSENT CASE

- Dr. K perform high velocity/ low amplitude spinal adjustments that demonstrated improvement in the patient's condition.
- After one of the treatments, her pain level increased and she went to the local ER where they diagnosed her with piriformis syndrome and sciatica.
- The next day she visited her MD for urinary retention. He dx a UTI and indicated she could continue chiropractic care.
- She return to Dr. K and he checked to see if she could tolerate flexion distraction technique. It was not a positive experience as the patient screamed out with pain and left his office.

31

INFORMED CONSENT CASE

- Patient returned to hospital the next day and after being evaluated was sent for surgery for cauda equine syndrome.
- The surgery left her with bowl and bladder dysfunction and loss of feeling in her sexual organs.
- Baby was delivered with no problems.

32

INFORMED CONSENT CASE

- One year later the patient initiates a lawsuit against everyone.
- After much legal maneuvering only Dr. K and the first MD, who eventually was also dismissed leaving only Dr. K
- Patient expert chiropractor claimed:
  - No informed consent
  - Did not fully evaluate her condition
  - Failed to refer in a timely manner preventing an earlier surgical option
  - Caused the cauda equine syndrome to worsen with the flexion distraction adjustment.

33

INFORMED CONSENT CASE

- At trial, plaintiff's chiropractic expert found:
  - Deviations from proper standard of care by failing to order MRI and by adjusting the lumbar region further damaging the disc
  - Deviated from standard of care by not performing a proper informed consent procedure and that specifically cauda equina syndrome could occur as a result of spinal manipulations.

34

INFORMED CONSENT CASE

- Defense chiropractic expert testified:
  - DX and treatment plan were proper and within the standard of care.
  - "Standards of care do not require perfection"
- Jury findings:
  - Not negligent in treatment and did not cause her injury
  - **Found negligent in the tort of lack of informed consent, directly proximately causing injury to the patient**

35

SUMMARY OF CASES

- Failure points could have been avoided
- Hanneman
  - Multiple gaps in care
  - Treatment outside normal hours
  - "brief" examinations
- Dr. OK case
  - NO informed consent procedures

36

OBTAINING INFORMED CONSENT

- Informed consent is a process for getting permission before conducting a healthcare intervention on a person.
- An informed consent can be said to have been given based upon a clear appreciation and understanding of the facts, implications and consequences of an action.
- You need to evaluate for any impairments in reasoning or judgement that would preclude the patient from properly understanding and consenting.
  - Factors could include a high level of stress, intoxication, sleep deprivation, Alzheimer's disease or other similar conditions.
  - Children/ minors will need a parental informed consent to be signed.

37

OBTAINING INFORMED CONSENT

- Consent must be voluntary.
  - DC must not unduly pressure or coerce the patient into consenting to a particular treatment or procedure, but must instead convey that the patient is free to choose among any recommended treatments and procedures, including no treatment or to revoke a prior consent without prejudice to the patient's access to future health care or other benefits.
  - Killer subluxation

38

OBTAINING INFORMED CONSENT

- Must be an ongoing process. It isn't a one and done type procedure.
- If condition changes, you should re-visit the informed consent process.

39

ACA DEFINITION

- The American Chiropractic Association guidelines on Informed Consent recommend a DC:
  - Treat informed consent as an ongoing discussion throughout the patient's course of care.
  - Advise and describe the recommended course of action and discuss the benefits, risks and reasonable alternatives.
  - Determine that the patient reasonably understands the discussion
  - Provide an opportunity to ask questions
  - Note any refusal to follow recommendations
  - Document the elements of the informed consent in the patients records

40

ICA DEFINITION

- The International Chiropractic Association guidelines and Informed Consent form recommend:
  - Obtain a written informed consent signed by the patient and doctor
  - Provide an opportunity to discuss the nature and purpose of proposed treatment and answer the patient's questions
  - Results are not guaranteed and a doctor must use professional judgement during the course of care
  - Advise of possible complications, including stroke.

41

VALID INFORMED CONSENT

- Practitioner must:
  - Determine if the patient has decision-making capacity.
  - Provide information related to the six elements of an informed consent
  - Properly document consent by patient

42

Decision Making Capacity

- A clinical determination made by the practitioner that a patient has the requisite capacities to make a medical decision. (This is not the same as "competency" which is determined by the court.
  - Four major components:
    - Understanding
    - Appreciating
    - Formulating
    - Communicating
- The first 2 components represent the patient's ability to understand and appreciate the nature and expected consequences of each health care decision. This includes understanding the known benefits and risks of the recommended treatment options, as well as any reasonable alternative options including no treatment.
- The later 2 represent the ability to formulate a judgement and communicate a clear decision concerning health care

43

Six elements

- For the patient's consent to be valid, the DC needs to review the following six elements
  - The patient's diagnosis/condition and the proposed treatment, modality or procedures for correction.
  - The relevant risks and benefits of the proposed treatment, modality or procedures
  - Alternative treatment or procedures that are available to the patient and the relative risk, benefits, and uncertainties related to each alternative;
  - The risk and benefits of not receiving or undergoing any treatment procedure
  - The assessment of the patients understanding of the information provided (decision making capacity)
  - The acceptance by the patient to undergo the recommended treatment, modality or procedure.

44

Wisconsin Informed Consent Language

- **446.08 Informed consent.** Any chiropractor who treats a patient shall inform the patient about the availability of reasonable alternate modes of treatment and about the benefits and risks of these treatments. The reasonable chiropractor standard is the standard for informing a patient under this section. The reasonable chiropractor standard requires disclosure only of information that a reasonable chiropractor would know and disclose under the circumstances. The chiropractor's duty to inform the patient under this section does not require disclosure of any of the following:

(1) Detailed technical information that in all probability a patient would not understand.
(2) Risks apparent or known to the patient.
(3) Extremely remote possibilities that might falsely or detrimentally alarm the patient.
(4) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.
(5) Information in cases where the patient is incapable of consenting.
(6) Information about alternate modes of treatment for any condition the chiropractor has not included in his or her diagnosis at the time the chiropractor informs the patient.

45

6 ELEMENTS

- Element #1
  - The patient's diagnosis/condition and the proposed treatment, modality or procedures for correction.
  - Basically, a report of findings type communication with the patient signing a final document with the personal information included.

46

6 ELEMENTS

- Element #2
- The relevant risks and benefits of the proposed treatment, modality or procedures
- Risk:
  - the possible undesirable outcomes of a treatment or procedure, including known side effects, complications, serious social or psychological harms or other adverse outcomes.
  - Discussion of Stroke on every case
  - Full spine adjusters / Full spine examiners?

47

6 ELEMENTS

- Element #3
- Alternative treatment or procedures that are available to the patient and the relative risk, benefits, and uncertainties related to each alternative;

48

- Benefits and Risks of Neck Pain Treatments

Neck pain will affect about 70% of the population at some point in their lives and is a common reason many individuals seek help from a health care professional. A particular episode of neck-related problems can be mildly irritating, or it could be seriously debilitating.

While recent scientific studies have found that there are useful treatments for many neck-related problems, no one treatment has been shown to be effective in all cases. Commonly used physical treatments for neck pain include spinal manipulation, mobilization, massage, and therapeutic exercises. Common pharmaceutical treatments include acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs), muscle relaxant medications, and narcotic (opioid) pain medications.

All of the commonly used neck pain treatments carry some risk. Most of these risks are mild, but some can be serious.

49

- Physical Treatments: Manipulation, Mobilization, Massage and Exercise

Manipulation is a therapy in which a trained professional uses his/her hands to gently and quickly move abnormally stiff joints into their normal functional range of motion. Mobilization technique is similar, but it is usually performed more slowly.

Evidence from numerous clinical studies has shown that both manipulation and mobilization of the cervical spine (the neck) result in short-term improvements in pain and physical function, as well as lasting, long-term pain relief. The report by the *Bone and Joint Decade Task Force on Neck Pain and Its Associated Disorders*, referenced above, found 17 studies that looked at various manual therapies. It found overall positive evidence for both mobilization and manipulation, particularly when combined with exercise. This led the authors to include mobilization, manipulation and other manual therapies among the "likely helpful" treatments for simple neck pain.

A variety of minor side effects are commonly reported with all manual treatments for neck pain. These include temporary aggravations in symptoms or mild/moderate soreness following manipulation, mobilization, massage, or therapeutic exercises of the cervical spine.

The relation between manual treatments and serious complications is controversial. Numerous case reports have associated cervical spine manipulation with a rare type of stroke that results from a dissection (tear) of the vertebral artery, a blood vessel in the neck. These dissections are likely due to an underlying abnormality of the vascular system that usually can't be identified in advance, and are probably not directly caused by the manipulation. Unfortunately, the only early sign of an evolving dissection is neck pain and headache, symptoms that may lead people to seek treatment from a doctor of chiropractic or other professional.

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- **The largest study performed to date looked at the medical records of 11 million people in the Canadian Provence of Ontario over a nine year period and found that patients who went to a doctor of chiropractic for neck pain were no more likely to have a stroke following a chiropractic visit than patients who went to their primary care medical physician for neck pain (3).**

That study concluded that any observed association between a stroke and a patient's visit to either a chiropractic physician or a family medical physician was not directly caused by any treatment performed. Instead, any association was likely due to patients with an evolving vertebral artery dissection seeking care for symptoms such as neck pain or headache that sometimes take place before the stroke occurs.

The likelihood of a person having one of these rare vertebral artery strokes is about 1 to 3 per 100,000 people and is similar among both chiropractic patients and the general population.

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- Pharmaceutical Treatments: Acetaminophen, NSAIDs, Muscle Relaxant Medications and Narcotic

Simple analgesics such as acetaminophen (paracetamol) are commonly used to treat neck-related conditions. While generally safe at recommended doses, **acetaminophen is the largest cause of drug overdoses in the United States because of the narrow range between therapeutic dose and toxic dose . Every year in the United States, acetaminophen overdoses are responsible for 56,000 emergency room visits, 2,600 hospitalizations, and 458 deaths due to acute liver failure.**

NSAIDs are often used to treat neck-related conditions. Common side-effects include nausea, vomiting, and abdominal pain. NSAID use has been associated with a variety of serious adverse effects including bleeding and ulcers in the stomach and intestine, stroke, kidney failure, life-threatening allergic reactions, and liver failure.

One study published in *The New England Journal of Medicine* (5) estimated that at least 103,000 patients are hospitalized per year in the United States for serious gastrointestinal complications due to NSAID use.

These authors also estimated that there are 16,500 NSAID-related deaths annually in the United States, making this the 15th most common cause of death. This figure is similar to the annual number of deaths from AIDS, and is considerably greater than the number of deaths from multiple myeloma, asthma, or cervical cancer.

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Skeletal muscle relaxant drugs including benzodiazepines such as Diazepam (Valium®) are often used for treatment of neck pain. **The most commonly reported side effects are drowsiness, fatigue, and muscle weakness. Less common side effects include confusion, depression, vertigo, constipation, blurred vision, and amnesia .**

The use of narcotic (opioid) pain medications frequently leads to nausea, vomiting, constipation, and dizziness. Both muscle relaxants and narcotic pain medications produce drowsiness that may impair working or driving in about 1 in 3 patients.

Muscle relaxants and narcotics are associated with significant risk of abuse, addiction, dependence, withdrawal, seizures, potentially fatal injuries to the liver, and potentially fatal overdoses. Overdoses of opioid painkillers are responsible for some 15,000 deaths per year, more than the number of deaths from cocaine and heroin combined .

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- Comparative Effectiveness of Common Treatment

One review article concluded that there is moderate- to high-quality evidence that patients with some types of chronic neck pain have clinically important short-term and long-term improvements from a course of spinal manipulation or mobilization, but similar benefits were not seen from massage .

One recent study compared three groups of neck pain patients who were treated with 1) spinal manipulation, 2) an exercise program, or 3) medications, including NSAIDs, acetaminophen, or (in non-responsive patients) narcotic medications and/or muscle relaxants. **This study found that the patients who were treated with either spinal manipulation or the exercise program had significantly greater relief of pain in the short term and in the long term (up to one year after treatment ended).**

The *Bone and Joint Decade Task Force* review concluded that therapies that were "likely helpful" for non- traumatic neck pain included manipulation, mobilization, and exercises. **They concluded that there was "not enough evidence to make a determination" about the helpfulness of NSAIDs and other drugs.**

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- **Conclusion**

The current scientific evidence indicates that all commonly used treatments for neck pain have limited evidence of effectiveness. All treatments come with fairly common but mild side effects, and some have rare but potentially serious side effects.

In general, the physical treatments (including manipulation, mobilization, massage and exercise) have fairly good evidence of effectiveness and are very rarely associated with any serious complications. Pharmaceutical treatments, although commonly used, have limited evidence of effectiveness for treatment of neck pain, and infrequent but potentially serious complications.

In conclusion, there is good epidemiological evidence that the odds of having a stroke following a visit to a doctor of chiropractic are no greater than the odds of having a stroke following a visit to a primary care doctor (3). In addition, there is biomechanical evidence that cervical manipulation stretches the vertebral arteries less than routine examination procedures (11), making it unlikely that a cervical manipulation can physically cause an arterial dissection. **There is evidence that a manual approach to neck pain including manipulation is at least as effective as a conventional approach using NSAIDs and/or opiates (9) with no greater risk of complications.**
Neck pain patients who do not present with signs or symptoms of serious underlying disease should be given the choice of whether to pursue manual treatments, pharmaceutical treatments or a combination of both. Shared decision making should be based on complete and unbiased information, and patient preference should be respected.

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- **How Safe Is Chiropractic Care?**

- **Chiropractic: A Safe Treatment Option**

Chiropractic is widely recognized as one of the safest drug- free, non-invasive therapies available for the treatment of back pain, neck pain, joint pain of the arms or legs, headaches, and other neuromusculoskeletal complaints. Although chiropractic has an excellent safety record, no health treatment is completely free of potential adverse effects.

The risks associated with chiropractic, however, are very small. Many patients feel immediate relief following chiropractic treatment, but some may sometimes experience mild soreness or aching—similar to what they experience after some forms of exercise—headaches and tiredness. Current literature shows that minor discomfort or soreness following spinal manipulation typically fades within 24 hours.

In addition to being a safe form of treatment, spinal manipulation is incredibly effective, getting patients back on their feet faster than traditional medical care. For example, a 2010 study in the medical journal *Spine* found that patients with acute low back pain who received spinal manipulation achieved equivalent or superior improvement in pain and function when compared with other commonly used interventions, such as physical modalities, medication, education, or exercise, at short, intermediate and long-term follow-up.

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- **How Safe Is Chiropractic Care?**

Neck Adjustments
Neck pain and some types of headaches are treated through precise cervical manipulation. Cervical manipulation, often called a neck adjustment, works to improve joint mobility in the neck, restoring range of motion and reducing muscle spasm, which helps relieve pressure and tension. Patients typically notice a reduction in pain, soreness, and stiffness, along with an improved ability to move the neck.
Neck manipulation is a remarkably safe procedure. While some reports have associated upper high-velocity neck manipulation with a certain kind of stroke, or vertebral artery dissection, recent evidence2 suggests that patients are no more likely to suffer a stroke following a chiropractic neck treatment than they are after visiting their primary care medical doctor's office—and concluded that vertebrobasilar artery (VBA) stroke is a very rare event, and that this type of arterial injury often takes place spontaneously, or following everyday activities such as turning the head while driving, swimming, or having a shampoo in a hair salon.
Patients with this condition may experience neck pain and headache that leads them to seek professional care— often at the office of a doctor of chiropractic or medical doctor—**but that care is not the cause of the injury.** The best evidence indicates that the incidence of artery injuries associated with high-velocity upper neck manipulation is extremely rare – about 1 case in 5.85 million manipulations.
To put this risk into perspective, if you drive more than a mile to get to your chiropractic appointment, you are at greater risk of serious injury from a car accident than from your chiropractic visit.

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6 ELEMENTS

- Element #4
- The risk and benefits of not receiving or undergoing any treatment procedure

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6 ELEMENTS

- Element #5
- The assessment of the patients understanding of the information provided (decision making capacity)

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6 ELEMENTS

- Element #6
- The acceptance by the patient to undergo the recommended treatment, modality or procedure.

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DOCUMENTATION

- Are written informed consent forms required?
- What should be included documentation in the patient's chart?

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HOW TO RECORD

- Check your state statutes and rules to determine any requirements on how the patient is to be informed.
- Does the information need to be provided through written, oral or any combination?

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DOCUMENTATION OF INFORMED CONSENT

- Recommended Minimal documentation:
  - "discussed findings with patient including....."
  - "discussed my recommendations for care including...."
  - "discussed the following risks and benefits including alternate treatment....."
  - "the patient appeared to understand and agreed to proceed with my recommended treatment plan."

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DOCUMENTATION

- Make it routine to document the presence or absence of contraindications and red flags following exams/ re-exams
- Make it routine to document the patient's immediate reaction to treatment.

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DOCUMENTATION

- Red Flags
  - potential herniated discs
  - sudden onset of severe headaches or pain in the upper neck
  - sudden difficulty speaking or slurred speech
  - sudden onset of confusion or altered mental status
  - Sudden tingling on one side of the face or body (both)
  - sudden onset of dizziness or unsteadiness, loss of balance or coordination or both
  - sudden difficulty walking or standing upright
  - sudden trouble with vision or sight.
  - loss of bowel or bladder control

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DOCUMENTATION SUMMARY

- Document the patient encounter when obtaining informed consent in your notes.
- Patient initials for each element
- Patient sign informed consent document
- Continued documentation on each visit include the effects of the adjustment and if a new informed consent is necessary.

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Standards of Care

- Reasonable patient standard
- Reasonable physician standard
- Reasonable chiropractic standard (Wisconsin only)

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Reasonable Patient Standard

- whether a reasonable patient would have considered the information sufficient to make an informed decision.
- The problem with Dr. Google.

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Reasonable Physician Standard

- A standard of disclosure of information used in the wording of informed consent documents, based on customary practice or what a reasonable practitioner in the medical community would disclose under the same/similar circumstances.

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Reasonable Chiropractic Standard

- Only in Wisconsin!
- Based on what a reasonable chiropractor would disclose
  - MD's can't testify against us

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Wisconsin Law

- New Wisconsin statute
  - Reasonable chiropractic standard
  - 6 exceptions

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- **446.08 Informed consent.** Any chiropractor who treats a patient shall inform the patient about the availability of reasonable alternate modes of treatment and about the benefits and risks of these treatments. The reasonable chiropractor standard is the standard for informing a patient under this section. The reasonable chiropractor standard requires disclosure only of information that a reasonable chiropractor would know and disclose under the circumstances. The chiropractor's duty to inform the patient under this section does not require disclosure of any of the following:

(1) Detailed technical information that in all probability a patient would not understand
(2) Risks apparent or known to the patient
(3) Extremely remote possibilities that might falsely or detrimentally alarm the patient
(4) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment
(5) Information in cases where the patient is incapable of consenting
(6) Information about alternate modes of treatment for any condition the chiropractor has not included in his or her diagnosis at the time the chiropractor informs the patient.

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6 EXCEPTIONS

- (1) Detailed technical information that in all probability a patient would not understand.
- (2) Risks apparent or known to the patient.
- (3) Extremely remote possibilities that might falsely or detrimentally alarm the patient.
- (4) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.
- (5) Information in cases where the patient is incapable of consenting.
- (6) Information about alternate modes of treatment for any condition the chiropractor has not included in his or her diagnosis at the time the chiropractor informs the patient.

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PROCEDURES

- Sign informed consent form as part of the paper intake process
  - Generic form
- No form, just provide ROF
- Properly providing information and obtaining verbal and written consent prior to treating.

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PROCEDURES

- Provide information to patient
- Ascertain ability to understand and agree to information
- Obtain consent
- Document in notes
- Have patient sign a form

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SUMMARY

- Informed consent is not simply a form
- Procedures to obtain initial consent
- Not a one and done process. Need to continually monitor additional settings that will require new consent to be obtain.
- What information is required to achieve proper consent
- What about the Stroke issue

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MEDICAL MALPRACTICE LAWYERS

- Here are some examples of negligence resulting in misdiagnosis.
- **Failing to listen to the patient:** When patients tell their doctors that they aren't feeling well, it is the responsibility of their doctors to listen and examine these symptoms. Should a doctor fail to examine a symptom and his or her patient gets sicker, the doctor can be liable for a misdiagnosis.
- **Failing to recognize symptoms:** Doctors are trained to make diagnoses based upon their patients' symptoms. If a healthcare professional fails to make an accurate diagnosis, despite symptoms indicating a particular illness, he or she may be held liable for medical malpractice.
- **Failing to examine medical history:** Physicians have a responsibility to examine their patients' personal and family medical histories. A physician may be considered negligent if he or she didn't examine a patient's medical history, the patient becomes sicker, and the illness would have been easily identifiable after examining the patient's medical history.

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MEDICAL ERRORS

- According to a study that analyzed more than 300 medical claims between 2007 and 2013, the following health issues were the most commonly misdiagnosed.
- Stroke
- Heart attack
- Spinal epidural abscess
- Pulmonary embolism
- Necrotizing fasciitis
- Meningitis
- Testicular torsion
- Subarachnoid hemorrhage
- Septicemia
- Lung cancer
- Fractures
- Appendicitis

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MEDICAL ERRORS

- Medication Errors
  - Another major medical error that affects public health in the United States is incorrect medications or dosages of those medications. It costs over $40 billion per year to care for and treat patients who were victims of medication errors.
  - In the United States, between 7,000 and 9,000 patients die from medication errors every year.
  - The types of errors that fall under this category include:
    - Prescribing the wrong medication.
    - Failing to include a necessary part of the prescription.
    - Telling the patient to take the prescription at the wrong time of day.
    - Giving the improper dose of medication.
    - Failing to check whether the patient is allergic to that medication.
    - Failing to check whether there are other medications the patient takes that could interact with the prescribed drug.
    - Transcribing the prescription incorrectly.

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MEDICAL ERRORS

- What Causes Medical Errors?
- What are the factors that go into creating a medical error, and are they fixable? Can we reduce the number of medical errors, and more importantly, the adverse effects of these errors on patients?
- We review a few of the most typical components that, in combination or alone, cause the vast majority of medical errors in the United States.
  - Lack of training
  - Assigning tasks to inappropriate staff
  - Rare or copy-cat illnesses
  - Lack of adequate testing
  - Time-sensitivity—the treatment or procedure must be done immediately
  - Complexity of the illness or health issue being treated
  - Age of the patient
  - New procedures

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SUMMARY

- Chiropractic errors can be reduced through proper compliance procedures and policies.

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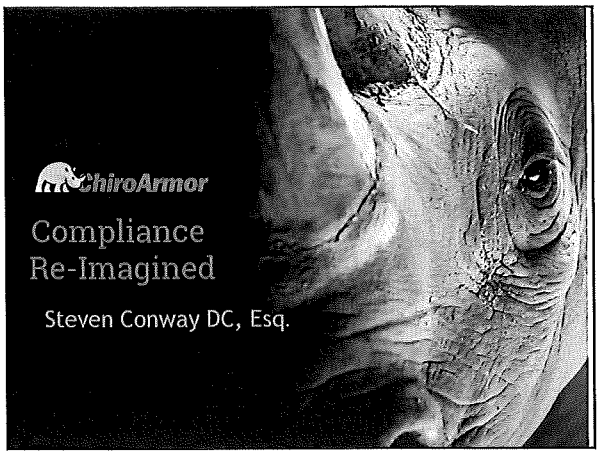

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