ChiroArmor

Medicare Policy Compliance Workshop

Dr. Scott Munsterman, DC, FICC, CPCO

Disclaimer

The topics taught here are for the sole purpose of the chiropractic profession, any transference to other healthcare disciplines are at the risk of the individual's discretion. The presenter is an investor in the Best Practices Academy. The Best Practices Academy denies responsibility or liability for any erroneous opinions, analysis, and coding misunderstandings on behalf of individuals undergoing this course.

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference. We have based the majority of this program on the guidelines set forth by the CMS, NCQA, URAC, AAAHC, AHRQ, The Compliance Team and other agencies involved in health care standards and research dissemination, as it relates to the chiropractic profession. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

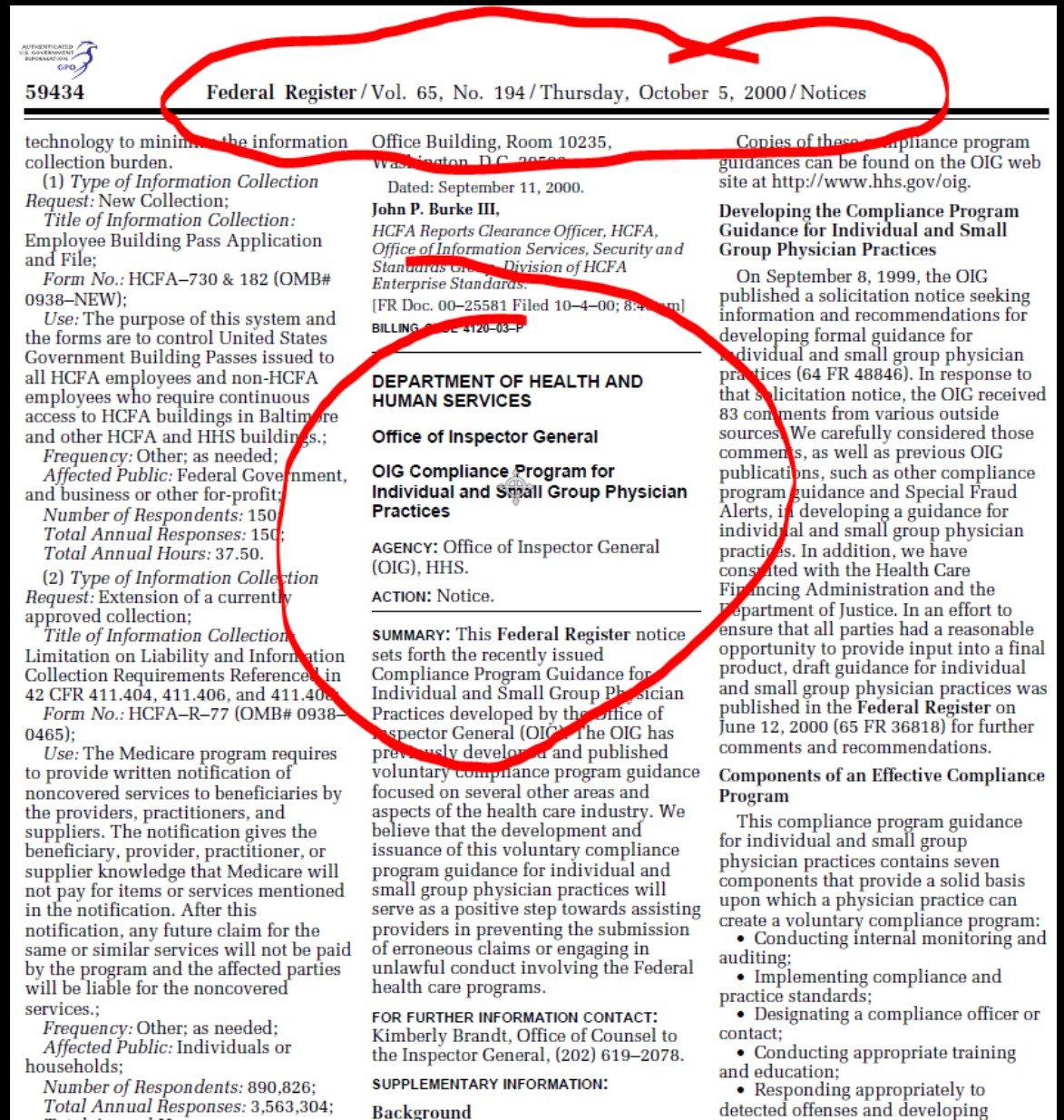
No legal advice is given in this program, and we encourage you to refer any such questions to your healthcare attorney.

Medicare Policy Compliance

- **PART I: Compliance Program Requirements**
- PART II: Medicare Documentation Requirements
- PART III: Federal Health Care Regulations
- PART IV: Enrollment and Participation

PART I
Compliance Program Requirements

OIG Requirements for Health Care Entities



59434 Federal Register / Vol. 65, No. 194 / Thursday, October 5, 2000 / Notices

technology to minimize the information collection burden.

(1) *Type of Information Collection Request:* New Collection;
Title of Information Collection: Employee Building Pass Application and File;
Form No.: HCFA–730 & 182 (OMB# 0938–NEW);
Use: The purpose of this system and the forms are to control United States Government Building Passes issued to all HCFA employees and non-HCFA employees who require continuous access to HCFA buildings in Baltimore and other HCFA and HHS buildings.;
Frequency: Other; as needed;
Affected Public: Federal Government, and business or other for-profit;
Number of Respondents: 150;
Total Annual Responses: 150;
Total Annual Hours: 37.50.

(2) *Type of Information Collection Request:* Extension of a currently approved collection;
Title of Information Collection: Limitation on Liability and Information Collection Requirements Referenced in 42 CFR 411.404, 411.406, and 411.408;
Form No.: HCFA–R–77 (OMB# 0938–0465);
Use: The Medicare program requires to provide written notification of noncovered services to beneficiaries by the providers, practitioners, and suppliers. The notification gives the beneficiary, provider, practitioner, or supplier knowledge that Medicare will not pay for items or services mentioned in the notification. After this notification, any future claim for the same or similar services will not be paid by the program and the affected parties will be liable for the noncovered services.;
Frequency: Other; as needed;
Affected Public: Individuals or households;
Number of Respondents: 890,826;
Total Annual Responses: 3,563,304;

Office Building, Room 10235, Washington, D.C. 20503.

Dated: September 11, 2000.

John P. Burke III,

HCFA Reports Clearance Officer, HCFA, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards.

[FR Doc. 00–25581 Filed 10–4–00; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

OIG Compliance Program for Individual and Small Group Physician Practices

AGENCY: Office of Inspector General (OIG), HHS.

ACTION: Notice.

SUMMARY: This **Federal Register** notice sets forth the recently issued Compliance Program Guidance for Individual and Small Group Physician Practices developed by the Office of Inspector General (OIG). The OIG has previously developed and published voluntary compliance program guidance focused on several other areas and aspects of the health care industry. We believe that the development and issuance of this voluntary compliance program guidance for individual and small group physician practices will serve as a positive step towards assisting providers in preventing the submission of erroneous claims or engaging in unlawful conduct involving the Federal health care programs.

FOR FURTHER INFORMATION CONTACT: Kimberly Brandt, Office of Counsel to the Inspector General, (202) 619–2078.

SUPPLEMENTARY INFORMATION:

Background

Copies of these compliance program guidances can be found on the OIG web site at http://www.hhs.gov/oig.

Developing the Compliance Program Guidance for Individual and Small Group Physician Practices

On September 8, 1999, the OIG published a solicitation notice seeking information and recommendations for developing formal guidance for individual and small group physician practices (64 FR 48846). In response to that solicitation notice, the OIG received 83 comments from various outside sources. We carefully considered those comments, as well as previous OIG publications, such as other compliance program guidance and Special Fraud Alerts, in developing a guidance for individual and small group physician practices. In addition, we have consulted with the Health Care Financing Administration and the Department of Justice. In an effort to ensure that all parties had a reasonable opportunity to provide input into a final product, draft guidance for individual and small group physician practices was published in the **Federal Register** on June 12, 2000 (65 FR 36818) for further comments and recommendations.

Components of an Effective Compliance Program

This compliance program guidance for individual and small group physician practices contains seven components that provide a solid basis upon which a physician practice can create a voluntary compliance program:

- Conducting internal monitoring and auditing;
- Implementing compliance and practice standards;
- Designating a compliance officer or contact;
- Conducting appropriate training and education;
- Responding appropriately to detected offenses and developing

OIG Compliance Program Notification

https://www.federalregister.gov/documents/2000/10/05/00-25500/oig-compliance-program-for-individual-and-small-group-physician-practices

Affordable Care Act

OIG Set guidelines in FY 2000

Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions
SEC. 6401. PROVIDER SCREENING AND OTHER ENROLLMENT REQUIREMENTS UNDER MEDICARE, MEDICAID, AND CHIP.
(a) MEDICARE.—Section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) is amended—

''(7) COMPLIANCE PROGRAMS.— ''(A) IN GENERAL.—On or after the date of implementation determined by the Secretary under subparagraph (C), a provider of medical or other items or services or supplier within a particular industry sector or category shall, as a condition of enrollment in the program under this title, title XIX, or title XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category. ''(B) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A) for providers or suppliers within a particular industry or category. ''(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry or category. The Secretary shall, in determining such date of implementation, consider the extent to which the adoption of compliance programs by a provider of medical or other items or services or supplier is widespread in a particular industry sector or with respect to a particular provider or supplier category.''.

Medicare Enrollment (Opted In)

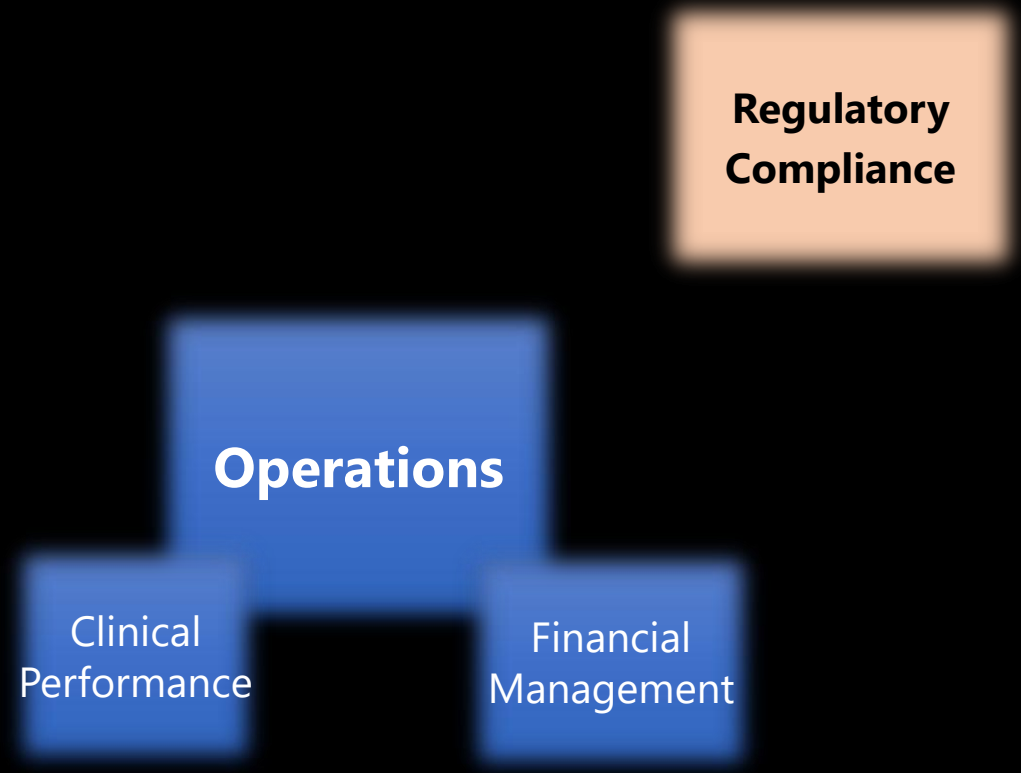
How does your compliance program work today?

Provide a brief explanation of your current compliance program and how it works in the practice…

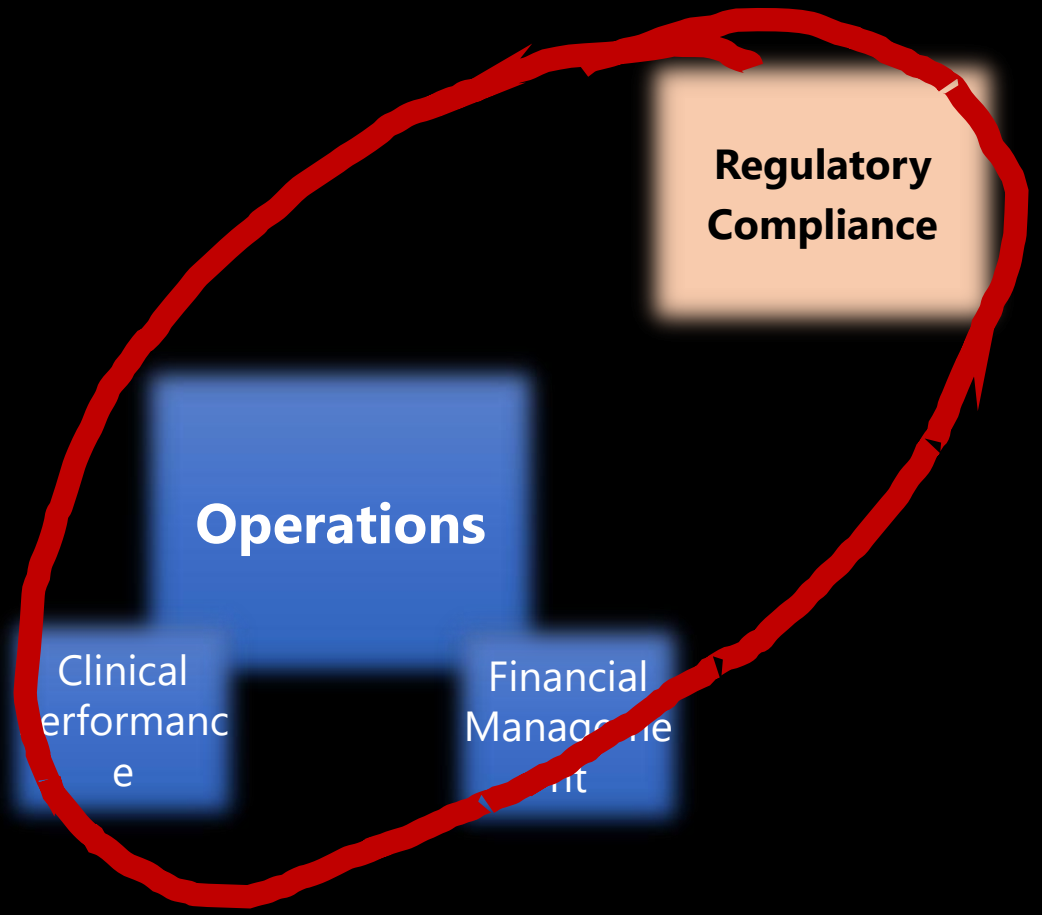
Goal: Help you Re-Imagine Compliance

*Sorry – this could get overwhelming

ChiroArmor



Most practice operations we encounter…



How do you make compliance a culture?

History of Compliance: 1992 - 1996

- University of Pennsylvania
- $30 million
- Referred to as Clinical Practices of University of Pennsylvania (CPUP)
- Inappropriate Medicare billing by teaching physicians:
  - Medical records didn't document supervision
  - Up coding
  - These audits are now known as PATH audits (Physician at Teaching Hospital)

1998 - 2000

Compliance Program Requirements cited in Federal Register for various health care stakeholders…

(hospitals, nursing homes, labs, hospice, DME, home health, nursing, ambulance, individual and group practices, pharma)

What is a compliance program?

Understanding the OIG's Requirements for a compliance program…

Office of Inspector General (OIG)

Seven Basic Components

1. **Designating a compliance officer**
2. Implementing Standards
3. Monitoring and auditing
4. Training and education
5. Responding to violations
6. Open communication
7. Enforcing disciplinary standards

Compliance Officer

The compliance officer for the practice is… and can be reached directly at …

Compliance Officer Duties and Responsibilities

Duties

- Oversee and monitor the implementation of the compliance program
- Establish methods to achieve and maintain compliance
- Periodically revise the compliance program
- Develop, coordinate, and participate in training
- Check OIG exclusion list and General Services Administration's list of parties barred from federal programs
- Investigate any report of possible issues

Who shouldn’t be the Compliance Officer?

Who shouldn't be the Compliance Officer?

Attorney (legal)

Financial Officer

Person directly involved in billing

What background/experience should the Compliance Officer have?

Business administration, clinical activities, coding, billing, reimbursement, risk management, general knowledge of the law/regulations.

Is your practice large enough to staff a compliance officer?

If not – what are your options?

Appoint Compliance Contacts who report to the Compliance Officer

Designating certain employees within the practice to perform specific compliance functions.

(i.e. audits, billing, monitoring procedures, etc.)

Outsource to an organization that serves as your Compliance Officer.

Interaction with a practice liaison who is designated to work with the outside Compliance Officer.

Office of Inspector General (OIG)

Seven Basic Components

1. Designating a compliance officer
2. **Implementing Standards**
3. Monitoring and auditing
4. Training and education
5. Responding to violations
6. Open communication
7. Enforcing disciplinary standards

Office of Inspector General (OIG)

Implementing Compliance and Practice Standards to address key risk areas through policy…

Policy must address these key areas:

HIPAA, OSHA, Labor Law, Medicare/Medicaid, Coding, Billing, & Documentation…

Employment Policy

Employment Policy Components

- Governance
- Administration
- Employment Applications
- Employment Relationship
- Non-Discrimination
- Non-Disclosure/Confidentiality
- New Employee Orientation
- Probationary Period for New Employees
- Office Hours
- Lunch Periods
- Break Periods
- Personnel Files
- Personnel Data Changes
- Inclement Weather/Emergency Closings
- Performance Review and Planning Sessions
- Outside Employment
- Corrective Action
- Employment Termination
- Safety
- Health Related Issues
- Employee Requiring Medical Attention
- Building Security
- Insurance on Personal Effects
- Supplies; Expenditures; Obligating the Company
- Expense Reimbursement
- Parking
- Visitors in the Workplace
- Immigration Law Compliance
- Attendance/Punctuality
- Absence Without Notice

- Harassment, including Sexual Harassment
- Telephone Use
- Public Image
- Substance Abuse
- Tobacco Products
- Internet Use
- Wage or Salary Increases
- Timekeeping
- Overtime
- Paydays
- Insurance
- Cobra Benefits
- Social Security/Medicare
- Simple IRA
- Vacation
- Record Keeping
- Holidays
- Jury Duty/Military Leave
- Educational Assistance
- Training and Professional Development
- Staff Meetings
- Bulletin Boards
- Suggestion Box
- Procedure for Handling Complaints

- Additional Policy:
- Financial Hardship
- Charity Care
- Patient Complaint & Grievance Policy
- Clinical Records Policy & Procedure
- Cleaning Policy & Procedure
- Hand Hygiene Policy & Procedure
- Informed Consent Policy
- Technology Policy

HIPAA POLICY

Privacy and Security

- Sensitive information is usually collected from employees and patients during hiring and business transactions, and privacy laws prevent businesses from disclosing this information freely.
- HIPAA has strict guidelines in place in the area of privacy and security for the health care industry.

ChiroArmor

HIPAA Privacy Rule

Defined a Record Set
Minimum Necessary Uses and Disclosures
Notice of Privacy Practices
Storing PHI
Transmitting PHI
Accounting of Disclosures

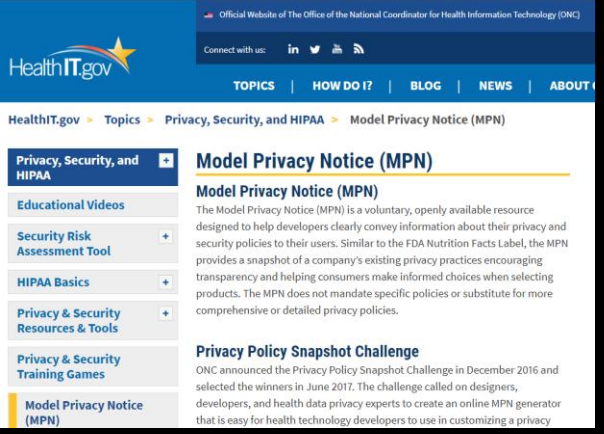
What is a covered entity?

What is a Business Associate?

Do HIPAA regulations apply to them differently than a Covered Entity?

Notices of Privacy Practices

The HIPAA Privacy Rule requires health plans and covered health care providers to develop and distribute a notice that provides a clear, user friendly explanation of individuals rights with respect to their personal health information and the privacy practices of health plans and health care providers.



ChiroArmor

Patient has the right to access their electronic information held in an electronic health record, if their provider has an EHR in their practice.

https://www.healthit.gov/topic/privacy-security-and-hipaa/model-privacy-notice-mpn

Very Important

A covered entity must make its notice available to any person who asks for it.

A covered entity must prominently post and make available its notice on any website it maintains that provides information about its customer services or benefits.

Patient should sign a privacy notice disclosure form that verifies the patient received the Privacy Notice.

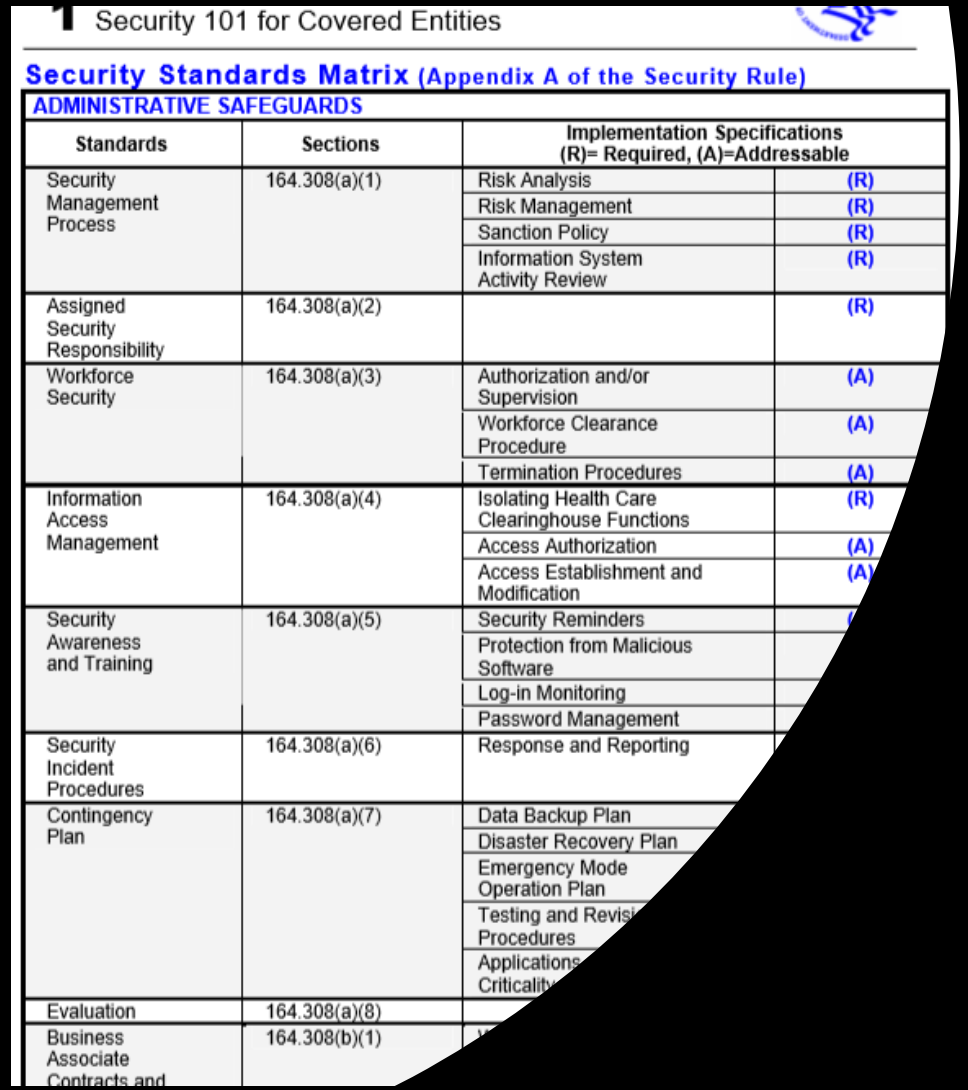
HIPAA Security Rule Requirements

Safeguards

Administrative

Physical

Technical



Security Standards Matrix (Appendix A of the Security Rule)

ADMINISTRATIVE SAFEGUARDS

Standards	Sections	Implementation Specifications (R)= Required, (A)=Addressable	
Security Management Process	164.308(a)(1)	Risk Analysis	(R)
		Risk Management	(R)
		Sanction Policy	(R)
		Information System Activity Review	(R)
Assigned Security Responsibility	164.308(a)(2)		(R)
Workforce Security	164.308(a)(3)	Authorization and/or Supervision	(A)
		Workforce Clearance Procedure	(A)
		Termination Procedures	(A)
Information Access Management	164.308(a)(4)	Isolating Health Care Clearinghouse Functions	(R)
		Access Authorization	(A)
		Access Establishment and Modification	(A)
Security Awareness and Training	164.308(a)(5)	Security Reminders	
		Protection from Malicious Software	
		Log-in Monitoring	
		Password Management	
Security Incident Procedures	164.308(a)(6)	Response and Reporting	
Contingency Plan	164.308(a)(7)	Data Backup Plan	
		Disaster Recovery Plan	
		Emergency Mode Operation Plan	
		Testing and Revisi Procedures	
		Applications Criticalit	
Evaluation	164.308(a)(8)		
Business Associate Contracts and	164.308(b)(1)		

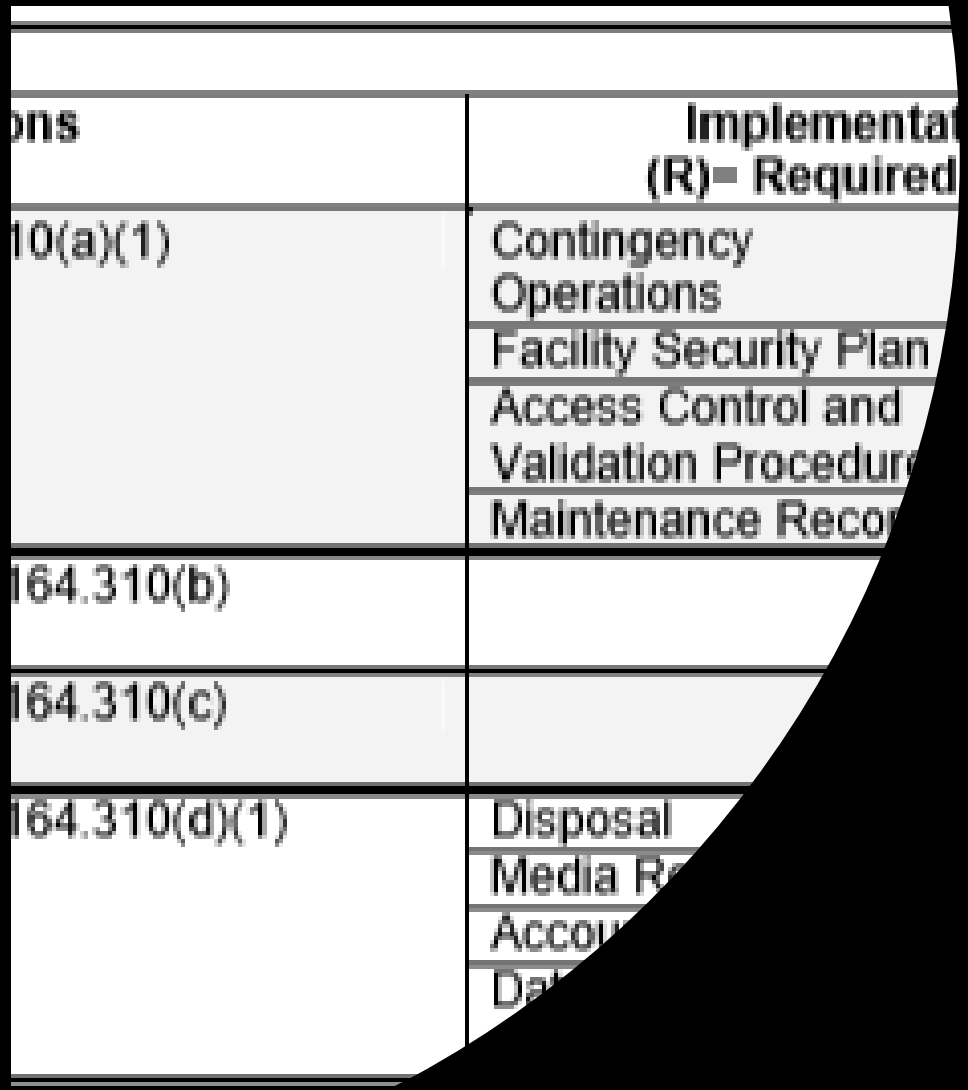
Administrative Safeguards

In general, these are the administrative functions that should be implemented to meet the security standards.

Administrative Safeguard Standards

- Log-in Monitoring
- Password Management
- Response and Reporting
- Contingency Plan
- Data Backup Plan
- Disaster Recovery Plan
- Emergency Mode Operation Plan
- Testing and Revision Procedures
- Applications and Data Criticality Analysis
- Evaluation
- Business Associate Contracts and Other Arrangements

- Risk Analysis
- Risk Management
- Sanction Policy
- Information System Activity Review
- Assigned Security Responsibility
- Authorized and Supervision
- Workforce Clearance Procedure
- Termination Procedures
- Healthcare Clearinghouse Functions
- Access Authorization
- Access Established and Modification
- Security Reminders
- Protection from Malicious Software



ons	Implementat (R)= Required
10(a)(1)	Contingency Operations
	Facility Security Plan
	Access Control and Validation Procedur
	Maintenance Reco
164.310(b)	
164.310(c)	
164.310(d)(1)	Disposal
	Media R
	Accou
	Da

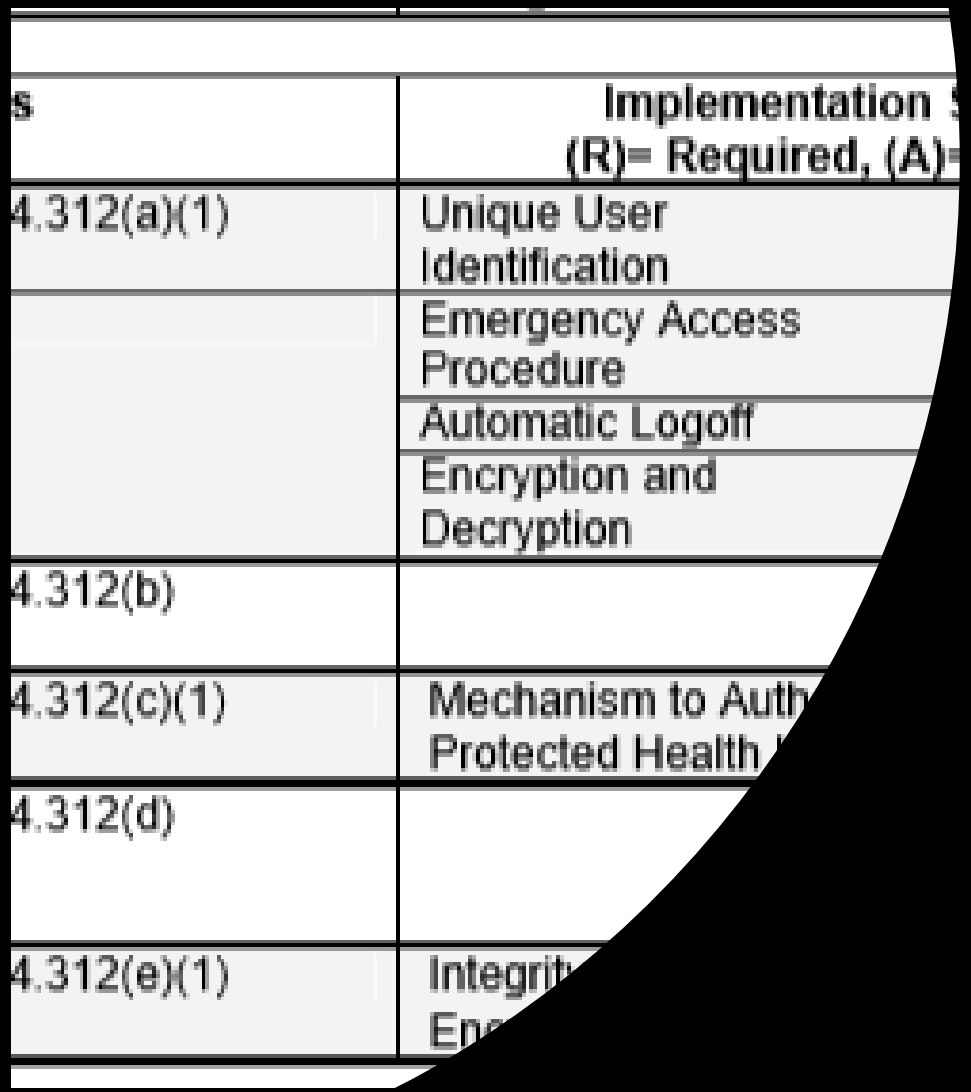
Physical Safeguard Standards

Physical Safeguards

In general, these are the mechanisms required to protect electronic systems, equipment and the data they hold, from threats, environmental hazards and unauthorized intrusion.

Physical Safeguard Standards

- Contingency Operations
- Facility Security Plan
- Access Control and Validation Procedures
- Maintenance Records
- Workstation Use
- Workstation Security
- Device and Media Controls
- Device and Media Controls – Disposal
- Device and Media Controls – Media Re-use
- Device and Media Controls – Accountability
- Device and Media Controls – Data Backup and Storage



s	Implementation (R)= Required, (A)=
4.312(a)(1)	Unique User Identification
	Emergency Access Procedure
	Automatic Logoff
	Encryption and Decryption
4.312(b)	
4.312(c)(1)	Mechanism to Auth Protected Health
4.312(d)	
4.312(e)(1)	Integrit En

Technical Safeguard Standards

Technical Safeguards

In general, these are primarily the automated processes used to protect data and control access to data.

Technical Safeguard Standards

- Access Control
- Unique User ID
- Emergency Access Procedure
- Automatic Log-off
- Encryption and Decryption
- Audit Controls
- Mechanism to Authenticate Electronic Patient Health Information
- Person or Entity Authentication
- Integrity Control
- Encryption

Security Risk Analysis

Conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the covered entity.

Includes addressing the security (including encryption) of electronic personal health information created or maintained by CEHRT; implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.

HIPAA Security Rule To Strengthen the Cybersecurity of Electronic Protected Health Information

898 Federal Register / Vol. 90, No. 3 / Monday, January 6, 2025 / Proposed Rules

https://www.hhs.gov/hipaa/for-professionals/security/hipaa-security-rule-nprm/factsheet/index.html

Purpose:

To modify the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule to strengthen cybersecurity protections for electronic protected health information (ePHI)

What does this Proposed Rule entail?

OSHA POLICY

Safety and Health

- The Safety and Health Act of 1970 ensures that employers provide safe and sanitary work environments through frequent inspections and a grading scale.
- In accordance with the 1970 act, employers must provide hazard-free workplaces, avoiding employee physical harm and death, through a number of procedures.
- Health care requirements: Blood-borne pathogens policy, hazardous waste, ergonomic policy

OSHA

What are the requirements for a practice under OSHA?

OSHA Requirements

General Safety Policy

Hazard Assessment

Bloodborne Pathogen Policy and Exposure Management Plan

Hazard Communication Program

Ionizing Radiation

Emergency Action Plan

Monitoring and Auditing

To have a successful compliance program,
you must show that the plan is improving
compliance within your practice.

Monitoring

Conducted on a regular (scheduled) basis to confirm compliance is ongoing (are procedures working as intended?).

Audit

Formal review of compliance of a particular set of standards (did you perform to the standard?).

Which of the practice's procedures should be audited?

ChiroArmor

There are 45 activities monitored and 12 key procedures audited throughout the year.

Each year.

ChiroArmor

Timely Policy Updates

Quarterly Documentation and Intake Audits with Compliance Review

ChiroArmor

How do you cover oversight of compliance to documentation standards in your practice?

Monitoring and auditing your documentation objectively – and independently.

Office of Inspector General (OIG)

Seven Basic Components

1. Designating a compliance officer
2. Implementing Standards
3. Monitoring and auditing
4. **Training and education**
5. Responding to violations
6. Open communication
7. Enforcing disciplinary standards

What mandatory training is required for your practice each year?

HIPAA
OSHA
Fraud, Waste, Abuse
Non-Discrimination in Healthcare

Coding and Documentation is strongly recommended by OIG/CMS

Some payers require cultural training

Conducting Appropriate Training and Education

Who?

What?

When?

How often?

Office of Inspector General (OIG)

Seven Basic Components

1. Designating a compliance officer
2. Implementing Standards
3. Monitoring and auditing
4. Training and education
5. **Responding to violations**
6. Open communication
7. Enforcing disciplinary standards

How do we respond if there is a violation of the policy?

Duty to Report

Report of Suspected Violation

Name (you may remain anonymous):

Home Address: Work Phone:

Home Phone: Office location:

Position:

Supervisor:

1. Description of possible violation:

2. When did this occur:

3. Person(s) involved:

4. How did you learn of this incident:

5. Do you have any evidence to prove the allegations? ☐ Yes ☐ No If so, please describe:

6. Would you be willing to discuss the above allegations with the Compliance Officer, practice administrator or Compliance Company? ☐ Yes ☐ No

7. Have you discussed the allegations with anyone else? ☐ Yes ☐ No If so, with whom?

8. Do you have any further information to provide or any suggestions for verifying the allegations described? ☐ Yes ☐ No

9. Are you aware of any other individuals who may be able to provide further information regarding the allegations? ☐ Yes ☐ No

Note: We will take every measure to ensure the confidentiality of the above information. However, there may be unforeseen circumstances where disclosure of this information may become necessary.

Duty to Report

It is the duty of each employee to promptly report any suspected violation of these standards to the corporate compliance officer.

Implementation and acceptance of this corporate compliance plan is intended to communicate specific current policies and codes of conduct. If any employee has a question concerning any of the provisions contained in the corporate compliance policy or concerning any policy not addressed in this document, he or she should confer with the compliance officer.

Office of Inspector General (OIG)

Responding Appropriately to Detected Violations

What are your warning indicators?

How are you fixing the problem?

Office of Inspector General (OIG)

Seven Basic Components

1. Designating a compliance officer
2. Implementing Standards
3. Monitoring and auditing
4. Training and education
5. Responding to violations
6. **Open communication**
7. Enforcing disciplinary standards

Open Lines of Communication

The Practice encourages an “open door” between providers, workforce members, and the Compliance Officer regarding any questions about billing or claims submission or other compliance issues.

All concerns may be reported direct to the compliance officer verbally by telephone, face to face, or in written format.

Office of Inspector General (OIG)

Developing Open Lines of Communication

Frank, professional candor allowed

"Open Door" policy

Standards of Conduct

- Comply with Laws and Regulations
- Act Ethically and Avoid Conflicts of Interest
- Practice adheres to the following procedure:
- Prepare and Submit Accurate and Complete Claims for Payment
- Participate in Compliance and Other Training Sessions
- Report Compliance Violations
- Cooperate with Internal and External Investigations

Office of Inspector General (OIG)

Seven Basic Components

1. Designating a compliance officer
2. Implementing Standards
3. Monitoring and auditing
4. Training and education
5. Responding to violations
6. Open communication
7. **Enforcing disciplinary standards**

Office of Inspector General (OIG)

Enforcing Disciplinary Standards through Well-Publicized Guidelines

What happens if…


Corrective Action Plan (CAP)

Date of CAP: _____ Revision Date (If Applicable): _____

Reason for CAP:

Errors or discrepancies were discovered/identified on _____ (date) through the following mechanism:

Description of resolution for error or discrepancy:

Repayment complete: [ ] Yes [ ] No [ ] Not Applicable

If Yes: Check Number: _____ Date: _____, Amount: _____

Legal counsel's recommendation of reporting corrective action to outside entities:

Billing policies or procedures modified, including date of modification(s):

Education or re-education undertaken as a result of this error/discrepancy:

Disciplinary actions taken as a result of this error/discrepancy:

Increased or focused audits and/or oversight will or will not (circle one) will be taken as a result of this error/discrepancy.

Description of audit focus and length of time that increased oversight will be taken, including, if applicable, levels of confidence of correction and continued compliance. (Example 95%) _____

CEO/Board of Trustees Notified? [ ] Yes [ ] No Date of Notification: _____

Means of Notification: _____

Other reasonable corrective measures taken:

Corrective Action Initiatives

"If you make a mistake, fix it as fast as you can..."

Zero Tolerance for Fraud Policy

I do hereby agree to abide by the information contained within including all standards of conduct, policies and procedures, and local, state and federal laws and regulations… I understand that failure to report a known violation of the compliance program is a breach of duty to report.

RECAP

Office of Inspector General (OIG)

Seven Basic Components

1. Designating a compliance officer
2. Implementing Standards
3. Monitoring and auditing
4. Training and education
5. Responding to violations
6. Open communication
7. Enforcing disciplinary standards

Medicare Policy Compliance

- PART I: Compliance Program Requirements
- **PART II: Medicare Documentation Requirements**
- PART III: Federal Health Care Regulations
- PART IV: Enrollment and Participation

PART IV
Medicare Documentation Requirements

Understanding how the oversight of the Office of Inspector General, HHS and MACs impact your risk for claims audits and recoupment of payments.

Comprehensive Error Rate Testing Program (CERT)

CMS program to establish error rates and estimates of improper payments.

CERT evaluates a statistically valid random sample of claims to determine proper payment under Medicare coverage, coding and billing rules.

Monitors the work of the MACs.

CERT Insider's Guide - Part B Third Quarter 2025

Comprehensive Error Rate Testing (CERT) program background

The CERT program measures payment compliance with Medicare fee-for-service (FFS) program federal rules, regulations, requirements and calculates an improper payment rate. CMS uses the CERT program to calculate a national improper payment rate as well as contractor and service specific improper payment rates using a stratified random sample of claims selected for review.

Fiscal year (FY) 2024 Medicare FFS estimated improper payment rate

The FY 2024 Medicare FFS estimated improper payment rate is 7.66%, representing $31.70 billion in improper payments. The table below outlines the improper payment rate and projected improper payment amount by claim type for FY 2024. The reporting period for this improper payment rate is for claims submitted July 1, 2022, through June 30, 2023.

Claim type	Improper payment rate	Improper payment amount
Overall	7.66%	$31.70 B (Billion)
Ambulance	13.2%	$595K
Chiropractic Services	33.6%	$178K
Drugs and Biologicals	1.6%	$174K

CERT claim reviews

The CERT Insider's Guide provides proactive insight into CERT audit activities for the t
of the next CERT report. The following services contributed to the highest improper p

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00307791

ChiroArmor

Q3 2025

Chiropractic Services

CERT finding	Resolution	Resource(s)
Documentation to support medical necessity is inadequate. Missing medical necessity supporting active/corrective treatment.	Medical record documentation must include a treatment plan. Medical record documentation must demonstrate active or corrective treatment.	Novitas: Billing and Coding: Chiropractic Services (A58345) Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15 – Covered Medical and Other Health Services, Sections 30.5, “Chiropractor’s Services” and 240, “Chiropractic Services General” Medicare Processing Manual, Pub. 100-04, Chapter 12, Section 220, "Chiropractic Services“ Medicare Learning Network (MLN) Article: 1232664 - Medicare Documentation Job Aid for Chiropractic Doctors Medicare Needs Better Controls to Prevent Fraud, Waste and Abuse Related to Chiropractic Services

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

2024 Medicare Fee-for-Service Supplemental Improper Payment Data

file:///C:/Users/scott/OneDrive/Desktop/nov-2024-medicare-ffs-supplemental-improper-payment-data_2024920.pdf

Appendix I: Projected Improper Payments by Provider Type for Each Claim Type

This series of tables is sorted in descending order by projected improper payments. All estimates in these tables are based on a minimum of 30 lines in the sample.

Table I1: Improper Payment Rates and Amounts by Provider Type: Part B

Providers Billing to Part B	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Clinical Laboratory (Billing Independently)	3,766	$1,348,919,758	25.5%	22.2% - 28.8%	4.1%
Internal Medicine	1,237	$1,155,045,801	14.2%	11.8% - 16.6%	3.5%
Nurse Practitioner	999	$747,670,322	11.9%	6.9% - 17.0%	2.3%
Physical Therapist in Private Practice	568	$659,222,324	15.8%	11.9% - 19.7%	2.0%
Ambulatory Surgical Center	275	$656,289,639	14.7%	6.1% - 23.3%	2.0%
Family Practice	738	$623,251,727	11.4%	8.9% - 13.9%	1.9%
Ambulance Service Supplier (e.g., private ambulance companies)	423	$595,144,661	13.2%	7.6% - 18.8%	1.8%
All Provider Types With Less Than 30 Claims	587	$501,693,123	8.9%	4.5% - 13.2%	1.5%
Nephrology	377	$440,742,440	18.6%	0.8% - 36.4%	1.3%
Cardiology	571	$266,717,348	7.8%	5.6% - 9.9%	0.8%
Diagnostic Radiology	750	$264,272,682	7.2%	5.0% - 9.4%	0.8%
Emergency Medicine	527	$261,580,943	10.4%	8.2% - 12.5%	0.8%
Hematology/Oncology	473	$251,423,012	6.0%	1.6% - 10.5%	0.8%
Ophthalmology	596	$249,962,591	3.2%	1.4% - 5.1%	0.8%
Podiatry	245	$216,903,925	11.2%	6.7% - 15.7%	0.7%
Pulmonary Disease	133	$200,571,666	19.7%	9.4% - 30.0%	0.6%
Physical Medicine and Rehabilitation	165	$187,017,490	13.9%	4.7% - 23.2%	0.6%
Physician Assistant	407	$184,980,031	6.4%	4.1% - 8.7%	0.6%
Clinical Psychologist	93	$184,487,728	20.8%	1.9% - 39.7%	0.6%
Radiation Oncology	138	$180,889,796	16.9%	7.4% - 26.3%	0.6%
Chiropractic	156	$178,324,416	33.6%	24.8% - 42.4%	0.5%
Dermatology	234	$170,121,431	5.1%	1.9% - 8.4%	0.5%
Hospitalist	240	$135,765,842	10.4%	6.9% - 14.0%	0.4%
Cardiac Electrophysiology	62	$133,532,776	19.3%	4.7% - 33.9%	0.4%
IDTF	366	$124,367,625	13.9%	5.6% - 22.2%	0.4%
Neurology	178	$120,238,913	7.3%	3.7% - 10.9%	0.4%
Psychiatry	120	$113,203,760	14.2%	5.7% - 22.6%	0.3%
Orthopedic Surgery	214	$111,653,564	3.9%	2.0% - 5.8%	0.3%
Gastroenterology	144	$106,354,336	10.9%	6.7% - 15.1%	0.3%
Otolaryngology	43	$99,364,238	10.5%	(0.8%) - 21.7%	0.3%
Unknown Provider Type	134	$98,200,278	23.7%	14.5% - 33.0%	0.3%
Portable X-Ray Supplier (Billing Independently)	113	$97,915,063	44.2%	22.0% - 66.4%	0.3%

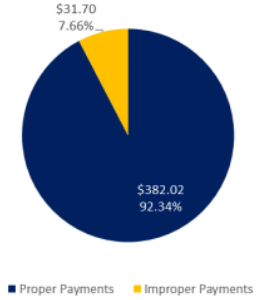
ChiroArmor

33.6%

The Highest of all providers…

92.34 Percent Accuracy Rate and 7.66 Percent Improper Payment Rate[1,2,3]

Figure 1: Payment Accuracy (in Billions)



Medicare Documentation Policy

Key compliance issues…

Areas of Risk:

- ✓Treatment Plan not provided
- ✓Mechanism of Trauma not identified
- ✓Subluxation not established
- ✓Changes since last visit not documented
- ✓Treatment Effectiveness not validated
- ✓Signature requirements not met
- ✓Scribes not identified
- ✓Someone other than the provider documenting the HPI and the exam
- ✓Medical necessity/Diagnosis coding issues
- ✓Cloning or other EMR issues
- ✓Incorrect category of E/M or CMT service billed
- ✓Improper use of modifiers/the need for a modifier not documented

“Chiropractic record improvement will require diligence to the educational process, purchase of the appropriate EHR software, attention to the implementation process, training of staff and chiropractors, appropriate utilization, and attentiveness to the data entry by the treating doctor.

It will also require the practitioner to maximize the existing features of the software and customize it to the practice.”

A Literature Review of Electronic Health Records in Chiropractic Practice: Common Challenges and Solutions David N. Taylor, DC J Chiropr Humanit. 2017 Dec; 24(1): 31–40. Published online 2017 Jan 18. doi: 10.1016/j.echu.2016.12.001

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5812902/

Standard of Care

Why should we document correctly?

Your documentation is the evidence of complying to expected standards of care of the profession and health care industry.

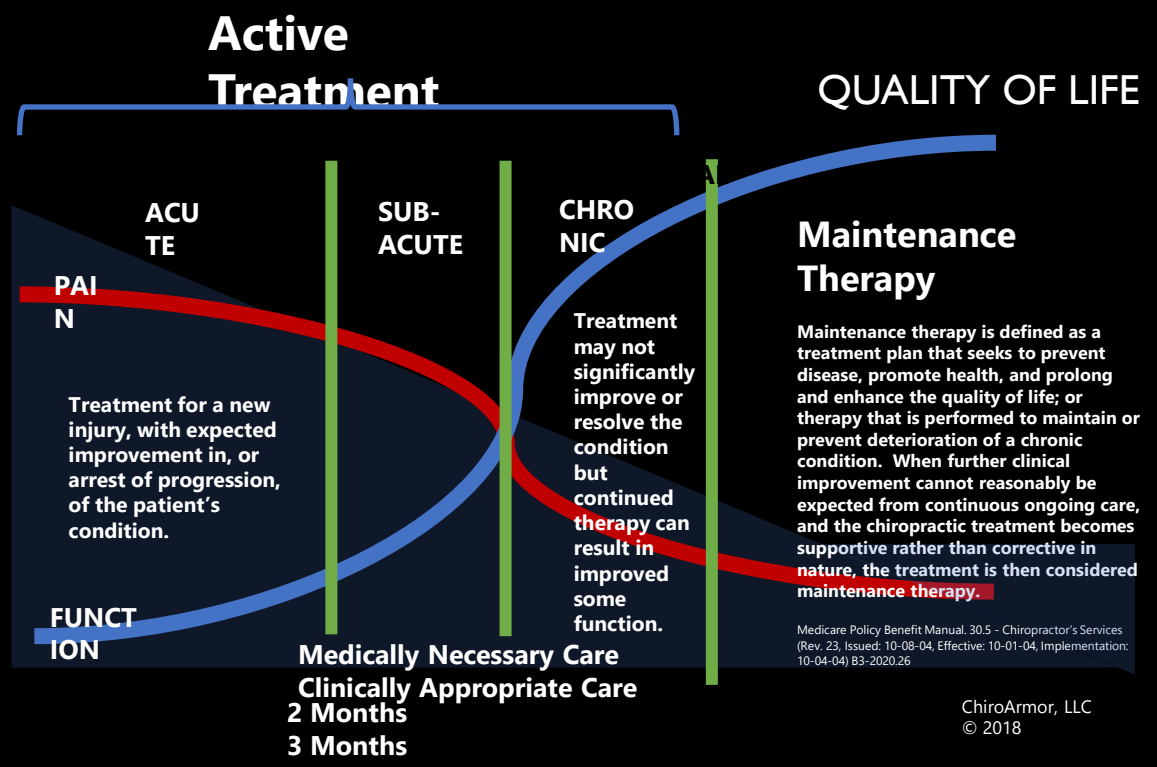
Clinical Standard of Care

Defining an Episode of Care

Establishing a beginning and an end to care; managing patient care in between.

Active Treatment versus Maintenance Therapy

A treatment plan is required.



Active Treatment (Medicare)

240.1.3 - Necessity for Treatment

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

Active Treatment

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**…

Acute Subluxation

A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above.

The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.

Chronic Subluxation

A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement.

Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

Maintenance Therapy

Under the Medicare program, Chiropractic **maintenance therapy is not considered to be medically reasonable or necessary, and is therefore not payable**. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to 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**. For information on how to indicate on a claim a treatment is or is not maintenance, see §240.1.3.

The Use of the Advanced Beneficiary Notice of Noncoverage (ABN) Form

The **Purpose of the ABN** is two-fold:

1) **Protection for the beneficiary** to allow them to choose whether they want services Medicare may not cover, and

2) **Protection for the provider**, allowing for the collection of payment from the patient if Medicare denies the service as not medically necessary.

ChiroArmor

Routine or blanket ABNs are usually not permitted.

An ABN should only be given to a Medicare beneficiary when the provider has reason to expect that Medicare will deny payment for some or all of the services.

Reason should be listed on the ABN.

https://ngsmedicare.com/ngs/portal/ngsmedicare/newngs/home-lob/pages/Manuals/part%20b_medicare%20coverage%20of%20chiropractic%20services/medicare%20coverage%20of%20chiropractic%20services%20-%20modifiers/!ut/p/z0/nY5Pi8IwEMW_Sjx4II_EDwGV9EVYcFLzUWmcVpnt01iGqt-e1tB8CS6t_k93pv3QEMC2mLNOUZ2FouGt3q8G6nlrN-fypWcr0ZSbb4mi4GaDOWPhG_Qrw3NB_49HrUCbZyNdImQ2Lwqac8GA901Gy2du_JJvrM_pUVD7ZSqK0u0Jyyaw2OIIt09rMK4mgLmJFwmzIGD8wFNZCMqCjUbarNve0VPIG7PGVOo2u2DsJ6uc9Ae46HHNnOQfNwPyT_7_Z9Or2fVuQHtpG6z/

Medical Necessity

Medical necessity is defined as services that are **reasonable and necessary** for the diagnosis or treatment of an illness or injury or to **improve the functioning** of a malformed body member and are not excluded under another provision of the Medicare Program.

DEFINITION OF LIMITED COVERAGE

NCDs are published at http://www.cms.gov/Manuals/IOM/list.asp on the CMS website.

The official versions of LCDs may be viewed by contractor, state, or alphabetically at http://www.cms.gov/mcd/indexes.asp on the CMS website.

BENEFICIARY RESPONSIBILITY

Services denied by the Medicare Program as not medically necessary can be billed to the beneficiary only if the beneficiary **chooses** to receive the service and **signs** a valid ABN **prior to the service(s) being furnished**.

The Use of the Advanced Beneficiary Notice of Noncoverage (ABN) Form

ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or fails to meet a technical benefit requirement (i.e. lacks required certification).

However, the ABN can be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered.

The Use of the Advanced Beneficiary Notice of Noncoverage (ABN) Form

The ABN form should be used whenever a patient requests documentation of a non-covered service, a non-payable covered service such as when the doctor discharges the patient from their episode of care and the patient chooses maintenance therapy.

ABN Triggering Event

Once the patient has **achieved the end-point of their episode of care** the patient is no longer considered under active treatment.

From that point moving forward, Medicare considers further treatment as **maintenance therapy** and non-payable.

ABN Form Options

Option #1

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

This option (1) allows the beneficiary to receive the items and/or services at issue and requires the doctor to submit a claim to Medicare. This will result in a payment decision that can be appealed. With this option selected by the patient, their secondary insurance can be billed. The patient may want to select this option for the charges to go towards their deductible.

ABN Form Options

Option #2

I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

This option (2) allows the beneficiary to receive the nonpayable items and/or services and pay for them out of pocket. No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

ABN Form Options

Option #3

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

This option (3) is the patient's choice to not receive the nonpayable items and/or services. And there are no appeal rights for the patient.

ABN Form

Finally, the patient **signs and dates the ABN form**. If you issue the ABN on an electronic screen, you must ask the beneficiary if he or she prefers a paper version and issue a paper ABN if he or she prefers such. The doctor is **required to give them a copy and keep one on file for 5 years from the date-of-care delivery** when no other requirements under State law apply. If the patient refuses or is unable to sign an ABN form, then:

- A representative of the beneficiary may sign. The form must note “rep” or “representative”.
- Consider not furnishing the item or service, unless the consequences (health/safety of the beneficiary) prevents this action.
- Provide the service and bill the claim as “Assigned” with modifier “GA”, documenting the signature refusal.

How often do we need to have the patient sign an ABN form?

An **ABN can remain effective for up to one year**.

ABNs may describe treatment of up to a year's duration **if a triggering event does not occur**. If a new triggering event occurs within the 1-year period, a new ABN must be completed. For instance, if they return to the practice with a new condition then the current ABN is no longer valid and you must start the patient on a new episode of care.

Key points to remember when completing an ABN form:

- Be specific in providing information
- Identify the service
- Provide a reason Medicare may not make payment
- Identify the estimated costs
- Beneficiary chooses the option they want
- Sign and date the ABN
- Provide copy to the patient

ABN Modifiers

AT

When you provide acute or chronic active treatment to Medicare beneficiaries, you must add the AT modifier. Only used for 98940, 98941, 98942

GP

Statutorily excluded services delivered under an outpatient physical therapy plan of care. Examples include: G0283-Electric Stimulation, 97035 Ultrasound, etc.

GA

Provided the ABN identifying a service that will be denied as not medically necessary. Provider is allowed to bill the patient.

GX

Report when you issue a voluntary ABN for a service Medicare never covers because it is statutorily excluded or is not a Medicare benefit. May use this in combination with modifier GY.

GY

Modifier is used to obtain a denial for a non-covered statutorily excluded service. May use in combination with modifier GX.

GZ

Did not provide the ABN but an ABN was required. Oops. Report when you expect Medicare to deny payment of the service due to a lack of medical necessity.

Cloning

- Very serious issue to CMS and OIG
- If your system allows you to bring forward documentation, you need to modify for the current information collected on the day of service.
- Need to identify information that is brought forward if not modified
- Initial exam and other data included in the documentation, but performed on the date of service.

CMS Comments

“Default documentation is a problem because it is difficult to tell what work was actually provided for the current visit.”

“Medical necessity documentation is a cognitive process that is difficult to document with templates and macros.”

“The volume of documentation should not influence the selection of the visit code.”

ChiroArmor

EHR templates are meant to prompt physician documentation.

Erroneous, contradictory, or cloned information

Potential for fraud

Lack of medical necessity

Patient care issues

Caution!!

Cloned notes may meet coding criteria but are not medically necessary if nothing changes from visit to visit.

Signature

24-48 hours

Signature

- Big Deal to Medicare
  - ✓Medicare requires a signature that is either handwritten 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.

Student Interns and Preceptorships

Medicare policy clearly defines the role of a student and the evaluation and management of a Medicare patient.

Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners, cited in Section 100.1.1 - Evaluation and Management (E/M) Services (Rev. 3971, Issued: 02- 02- 18, Effective: 01-01-18, Implementation: 03- 05-18)

Pursuant to 42 CFR 415.172 (b), documentation must identify, at a minimum, the service furnished, the participation of the teaching physician in providing the service, and whether the teaching physician was physically present.

E/M Service Documentation Provided by Students

Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable but are taken as part of an E/M service) must be **performed in the physical presence of a teaching physician** or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

E/M Service Documentation Provided by Students

Students may document services in the medical record. However, the teaching physician **must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision-making**.

The teaching physician **must personally perform (or re-perform) the physical exam and medical decision-making activities of the E/M service being billed** but may verify any student documentation of them in the medical record, rather than re-documenting this work.

Student Interns are not billing providers.

States do not give licenses to chiropractic students and therefore, they are never considered to be billing providers and their notes should not become part of the medical-legal record.

Medicare Policy does not allow for a non-licensed provider to perform services to a Medicare patient.

Therefore, chiropractic student interns working within the educational setting are not allowed to treat a Medicare patient, for billable services.

Combined Entries

On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.

False Claims Act

Inappropriate use of chiropractic student documentation by a teaching physician/preceptor (in accordance with Medicare rules) in support of a bill submitted to Medicare for Part B services may be considered fraudulent by the federal government and may lead to allegations of violating the False Claims Act.

Scribes

Always check with MAC for that region. In general the rules are:

A scribe can be an NPP, nurse or other appropriate personnel designated by the physician/NPP to document or dictate on their behalf. A scribe does not have to be an employee of the physician/NPP.

The medical record must clearly reflect:

- Who performed the service
- Who recorded the service
- A notation from the physician/NPP that he/she reviewed the documentation for accuracy
- Signed and dated by the performing physician/NPP

Scribes- Example

Identification of scribe

'Dictated by_____ ‘

Notation from physician/NPP that he/she reviewed for accuracy

'I agree with the above documentation' or 'I agree the documentation is accurate and complete'

Documentation Requirements

What does Medicare Benefit Policy Guidelines have to say about how we need to document the care of the patient?

History
Examination
Clinical Decision Making

Initial Visit Documentation Requirements

Essentials of an Initial Visit

- Patient history (HPI, Review of Systems, and PFMSH)
- Mechanism of Trauma established
- Chief Complaints
- Examination
- Informed Consent
- Problem/Diagnosis
- Treatment Plan
- Signature

History

- History of Present Illness and Subjective Complaints
- Past Family Social Medical history
- Review of Systems
- Outcome assessments / Pain scales (VAS or NRS)
- History containing **specific** functional limitations and restrictions/participaiton of daily activities and demands of employment

The Intake Process

This process has now become *VERY* important because:

- It determines the Chief Complaint of the Patient
- It determines the Correct Evaluation & Management Code Selection
- It provides a key component of Medical Necessity

Chief Complaint

- The chief complaint should be the first notation in all medical records and is required for all levels of history.

- It needs to be documented by the provider.

Chief Complaint

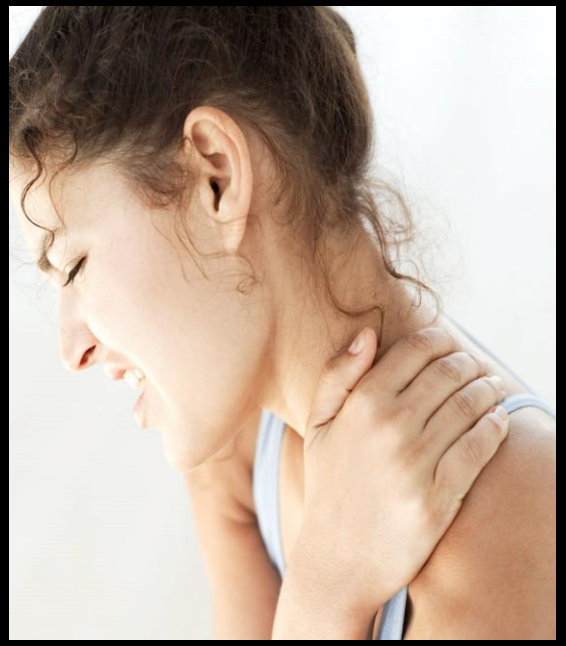
Examples:

- The patient presents today with a chief complaint of neck pain secondary to a motor vehicle accident.
- The patient presents today with a chief complaint of low back pain with radiation into the right posterior thigh.
- The patient states their chief complaint is in the mid-back and is achy in nature.

History of Present Illness (HPI)

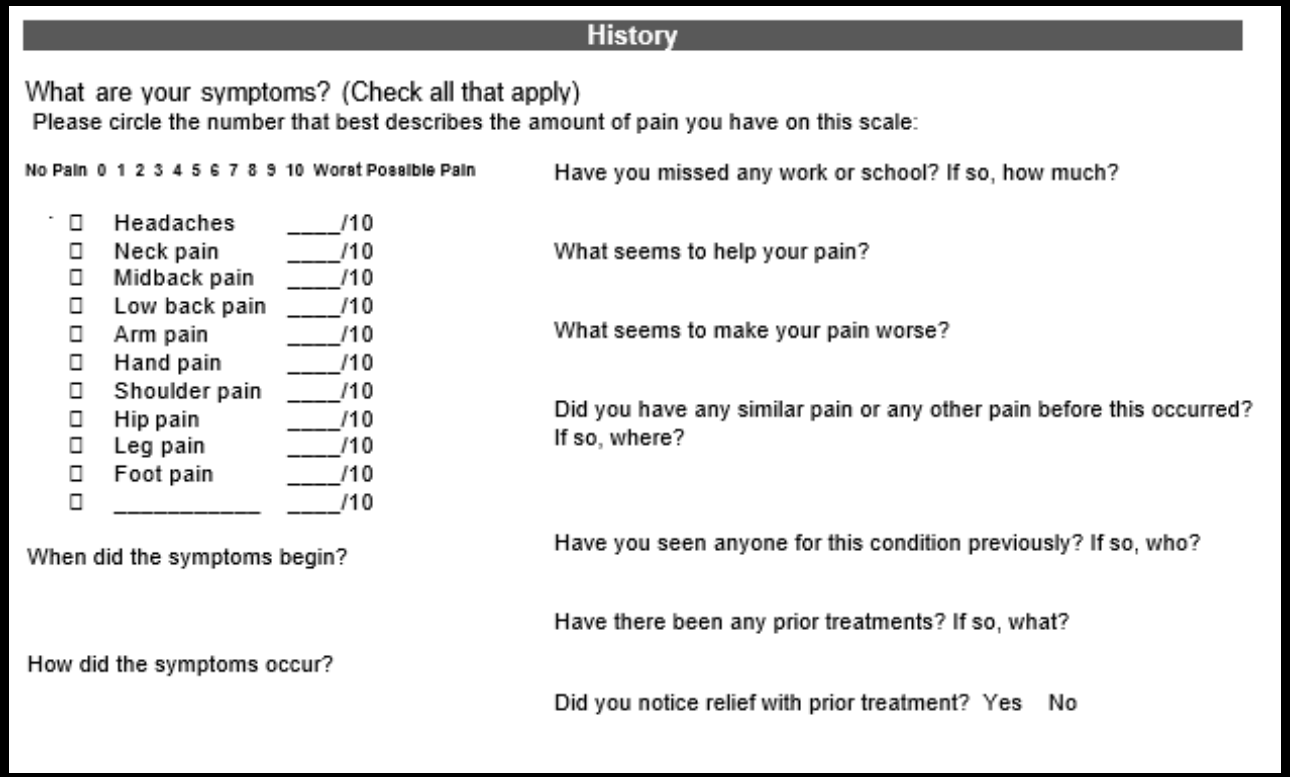
The History of Present Illness (HPI) clarifies in more detail the patient's chief complaint…

History of Present Illness
(HPI)



- Symptoms/Complaints
- Mechanism of Trauma
- Location
- Date of Onset
- Quality
- Intensity
- Duration
- Frequency
- Radiation of Symptoms
- Aggravation
- Palliation
- Prior Intervention

Patient Intake



History

What are your symptoms? (Check all that apply)

Please circle the number that best describes the amount of pain you have on this scale:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

- ☐ Headaches ____/10
- ☐ Neck pain ____/10
- ☐ Midback pain ____/10
- ☐ Low back pain ____/10
- ☐ Arm pain ____/10
- ☐ Hand pain ____/10
- ☐ Shoulder pain ____/10
- ☐ Hip pain ____/10
- ☐ Leg pain ____/10
- ☐ Foot pain ____/10
- ☐ _____ ____/10

When did the symptoms begin?

How did the symptoms occur?

Have you missed any work or school? If so, how much?

What seems to help your pain?

What seems to make your pain worse?

Did you have any similar pain or any other pain before this occurred? If so, where?

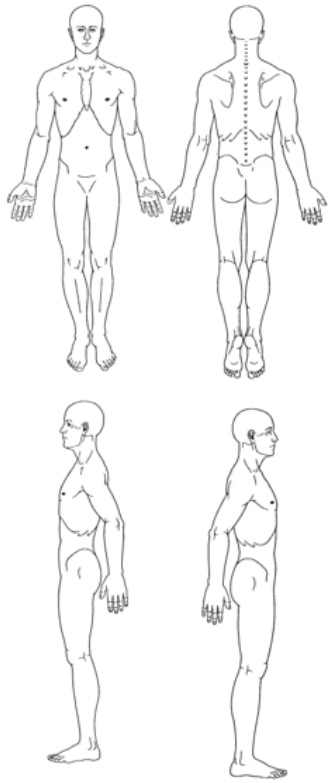
Have you seen anyone for this condition previously? If so, who?

Have there been any prior treatments? If so, what?

Did you notice relief with prior treatment? Yes No

Patient Intake

Please mark the areas of pain and draw lines if the pain radiates.



My pain is:

- ☐ constant
- ☐ aching
- ☐ intermittent
- ☐ radiating
- ☐ sharp
- ☐ throbbing
- ☐ numbness
- ☐ tingling
- ☐ burning
- ☐ tight
- ☐ nausea
- ☐ vomiting
- ☐ visual disturbance
- ☐ altered hearing
- ☐ ringing in ears
- ☐ loss of balance

My pain is aggravated by:

- ☐ Walking
- ☐ Stress
- ☐ Running
- ☐ Exercising
- ☐ Lifting Weight
- ☐ Jogging
- ☐ Climbing Stairs
- ☐ Bending Forward
- ☐ Bending Backwards
- ☐ Looking Up
- ☐ Looking Down
- ☐ Repetitious Movement
- ☐ Emotional Upset
- ☐ Flashing Lights
- ☐ Lifting Boxes
- ☐ Bowel movements

My pain is relieved by:

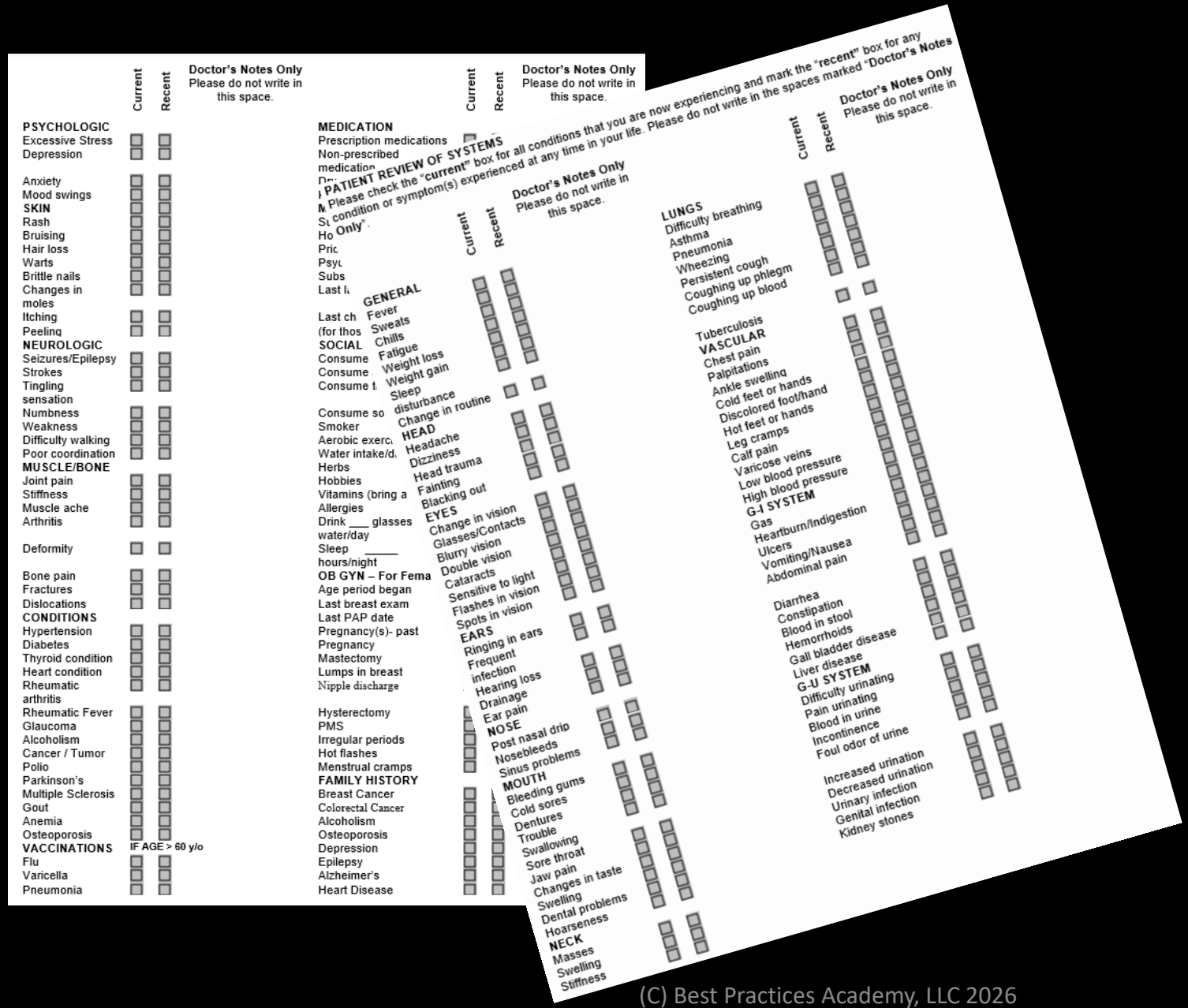
- ☐ chiropractic care
- ☐ antacids
- ☐ bowel movement
- ☐ lying still
- ☐ milk
- ☐ taking a deep breath
- ☐ taking a short nap
- ☐ painkillers
- ☐ sleep
- ☐ taking Ibuprofen or Tylenol
- ☐ exercising
- ☐ resting
- ☐ sitting

Indicate your ability to perform the following activities that are painful both before your condition or injury and now:

Activity	Before Injury (Minutes)	After Injury (Minutes)
Sitting		
Standing		
Driving		
Sleeping		
Walking		
	Before Injury (lbs)	**After Injury (lbs)**
Pushing		
Pulling		
Lifting		

Review of Systems (ROS)

A complete Review of Systems (ROS) should be updated with each new episode or follow-up clinical encounters within 12 months.



PSYCHOLOGIC
Excessive Stress
Depression
Anxiety
Mood swings
SKIN
Rash
Bruising
Hair loss
Warts
Brittle nails
Changes in moles
Itching
Peeling
NEUROLOGIC
Seizures/Epilepsy
Strokes
Tingling sensation
Numbness
Weakness
Difficulty walking
Poor coordination
MUSCLE/BONE
Joint pain
Stiffness
Muscle ache
Arthritis
Deformity
Bone pain
Fractures
Dislocations
CONDITIONS
Hypertension
Diabetes
Thyroid condition
Heart condition
Rheumatic arthritis
Rheumatic Fever
Glaucoma
Alcoholism
Cancer / Tumor
Polio
Parkinson's
Multiple Sclerosis
Gout
Anemia
Osteoporosis
VACCINATIONS
IF AGE > 60 y/o
Flu
Varicella
Pneumonia

Current
Recent
Doctor's Notes Only
Please do not write in this space.

MEDICATION
Prescription medications
Non-prescribed medication

PATIENT REVIEW OF SYSTEMS
Please check the "current" box for all conditions that you are now experiencing and mark the "recent" box for any condition or symptom(s) experienced at any time in your life. Please do not write in the spaces marked "Doctor's Notes Only".

GENERAL
Fever
Sweats
Chills
Fatigue
Weight loss
Weight gain
Sleep disturbance
Change in routine
HEAD
Headache
Dizziness
Head trauma
Fainting
Blacking out
EYES
Change in vision
Glasses/Contacts
Blurry vision
Double vision
Cataracts
Sensitive to light
Flashes in vision
Spots in vision
EARS
Ringing in ears
Frequent infection
Hearing loss
Drainage
Ear pain
NOSE
Post nasal drip
Nosebleeds
Sinus problems
MOUTH
Bleeding gums
Cold sores
Dentures
Trouble Swallowing
Sore throat
Jaw pain
Changes in taste
Swelling
Dental problems
Hoarseness
NECK
Masses
Swelling
Stiffness

LUNGS
Difficulty breathing
Asthma
Pneumonia
Wheezing
Persistent cough
Coughing up phlegm
Coughing up blood
Tuberculosis
VASCULAR
Chest pain
Palpitations
Ankle swelling
Cold feet or hands
Discolored foot/hand
Hot feet or hands
Leg cramps
Calf pain
Varicose veins
Low blood pressure
High blood pressure
G-I SYSTEM
Gas
Heartburn/Indigestion
Ulcers
Vomiting/Nausea
Abdominal pain
Diarrhea
Constipation
Blood in stool
Hemorrhoids
Gall bladder disease
Liver disease
G-U SYSTEM
Difficulty urinating
Pain urinating
Blood in urine
Incontinence
Foul odor of urine
Increased urination
Decreased urination
Urinary infection
Genital infection
Kidney stones

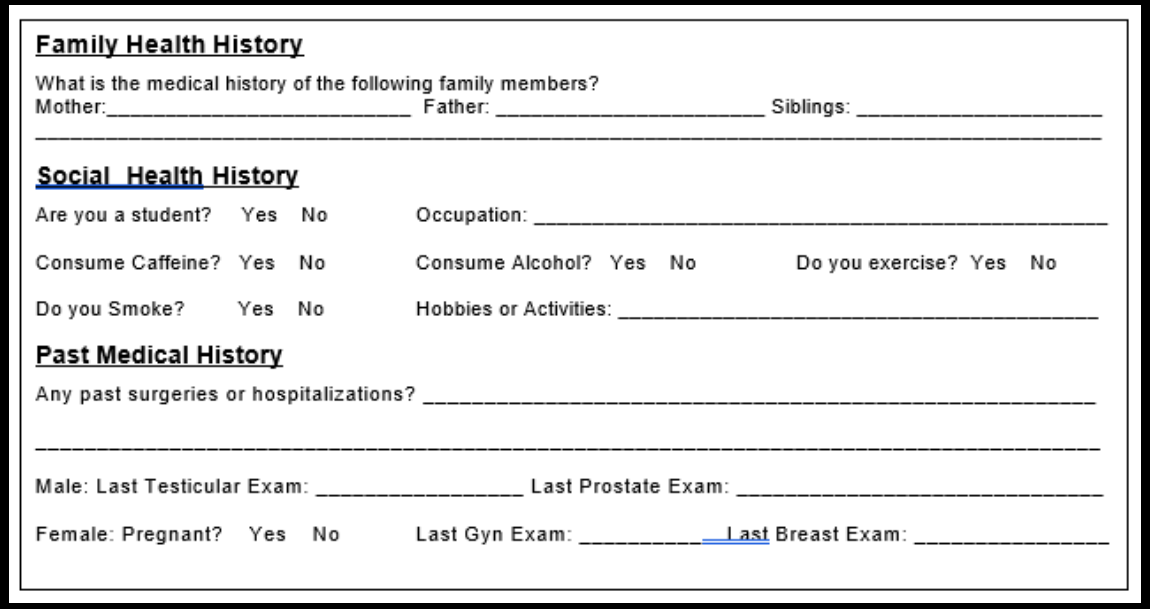
Review of Systems (ROS)

The 14 systems as per the *AMA CPT Code Book*:

1. Constitutional
2. Eyes
3. Ears, Nose, Mouth, Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/Lymphatic
14. Allergic/Immunologic

Past Family Medical Social History (PFMSH)

Patient Intake



Family Health History

What is the medical history of the following family members?
Mother:_____ Father: _____ Siblings: _____
_____

Social Health History

Are you a student? Yes No Occupation: _____

Consume Caffeine? Yes No Consume Alcohol? Yes No Do you exercise? Yes No

Do you Smoke? Yes No Hobbies or Activities: _____

Past Medical History

Any past surgeries or hospitalizations? _____

_____

Male: Last Testicular Exam: _____ Last Prostate Exam: _____

Female: Pregnant? Yes No Last Gyn Exam: _____ Last Breast Exam: _____

Past Family Medical Social History (PFMSH)

Past Family History

A review of the patient's family history to include any conditions or cause of death of parents, siblings, or children. This should include asking about diabetes, hypertension, cancer, or any other disease related to or that may delay recovery of the chief complaint.

Past Family Medical Social History (PFMSH)

Past Medical History

A review of the patient's past medical history should include information on previous occurrences of the chief complaint, surgeries, fractures, traumas, treatments, medications, and home therapies.

Past Family Medical Social History (PFMSH)

Past Social History

This should include information on marital status, occupation, educational level achieved, and current/previous use of alcohol, tobacco, and drugs.

Outcome Assessment Tools

Physical and Behavioral

ChiroArmor

Mechanism of Trauma

Insidious Onset

Time Lapse of Treatment

Determining Causation

Mechanism of Trauma

Symptoms corresponding and consistent with Mechanism of Trauma, Subluxation

AND

Function corresponding and consistent with Mechanism of Trauma, Symptoms, Subluxation, Goals of Care.

How should you document this?

Insidious onset?

Cause unknown?

What if the patient can’t recollect the cause of the onset?

Mechanism of Trauma Etiology Unknown

Rule out potential mechanisms and **document what didn't cause the condition**.

Document the initial date of treatment.

Six in 10 Americans have delayed seeking medical attention…

A variety of conditions were examined, and it was discovered that Americans are least likely to seek care for general aches and pains or a sprain, with insomnia, ringing ears and stiffness also making the list of most-ignored concerns.

Procrastination

Stages of delays in seeking treatment

- **Appraisal Delay: Am I ill?**
  - ▪ We walk around with symptoms all the time (sore throat, upset stomach)
  - ▪ We must come to the conclusion that we actually are sick
- **Illness delay: Do I need medical attention?**
  - ▪ Not all illnesses need medical attention
- **Behavioral Delay: Time until you make an appointment**
  - ▪ Pretty short for all of us
  - ▪ Option for us: Vaden
  - ▪ For people who don't have an existing option, no regular care provider,
  - this delay is longer
- **Scheduling delay: Time until you receive medical attention**
- **Treatment delay: Time until you begin treatment**

https://quizlet.com/193624922/lecture-14-delays-in-seeking-treatment-flash-cards/

Results showed that the most common reasons for delaying care are…

Financial concerns (51 percent), not believing it's a serious issue (42 percent), being too busy (30 percent), And even if recommended by a medical professional, about one in 10 would be unwilling to wear a back brace, glasses or hearing aids out of fear that it would be uncomfortable (54 percent) and/or too expensive (40 percent). Americans (27%) say they're too stressed to seek care, while 26 percent don't want to receive an unwanted diagnosis.

https://nypost.com/2018/10/22/why-most-people-delay-seeking-medical-attention/

Who delays seeking care? Major factor: perceived expense of treatment

Delay is more common:

- Among people who have no regular contact with a physician
- When symptoms resemble past symptoms that proved to be minor
- If the primary symptom is atypical
- If the illness is associated with social stigma

Delay in Seeking Medical Care

Social support refers to the process of interaction in relationships that improves coping, esteem, belonging and competence through actual or perceived exchanges of financial, physical or psychosocial resources.

Prevalence and Causes of Delay in Seeking Medical Care Among Al-Madina Population, Saudi Arabia Anas yousef Alharbi 1, Abdulrahman Sulaiman Alhazmi 1 , Maged Abdullah Aljabri 1, Omar mohammed Alawaji 1, Mohammed khaled Almolhis 11.MBBS. Medical intern, College of Medicine,Taibah University, Madina, Saudi Arabia Received 4.11.2018, accepted 18.12.2018 Corresponding Author: Abdulrahman Sulaiman Alhazmi, E-mail: as.alhazmi@hotmail.com.

Key Questions

Gap in Care

Reisinger MW, Moss M, Clark BJ. Is lack of social support associated with a delay in seeking medical care? A cross-sectional study of Minnesota and Tennessee residents using data from the Behavioral Risk Factor Surveillance System. BMJ Open 2018;8:e018139. doi:10.1136/bmjopen-2017-018139

Was there a time the past 12 months when you needed to see a doctor but could not because of cost?”

Select the most important reason:

Potential responses may include cost, could not reach the office, could not get an appointment, too long of a wait in the waiting room, office was closed, lack of transportation and ‘other’ reason.

Have you delayed getting needed medical care for any of the following reasons in the last 12 months?

Delay in Seeking Medical Care

Only 27.4% of participants always seek medical care as soon as they feel they need it. Delayed seeking medical care due to a financial impediment was stated by 26.1% of the subjects. Merely 25.2% had health insurance. The language was the most important criteria when choosing health service providers for 42% of patients. Severe pain forces 40.1% of participants to seek medical care, while moderate pain drives only 4.3% to seek medical care while 58.9% seek medical care when the pain or discomfort increases with time

Prevalence and Causes of Delay in Seeking Medical Care Among Al-Madina Population, Saudi Arabia Anas yousef Alharbi 1, Abdulrahman Sulaiman Alhazmi 1 , Maged Abdullah Aljabri 1, Omar mohammed Alawaji 1, Mohammed khaled Almolhis 11.MBBS. Medical intern, College of Medicine,Taibah University, Madina, Saudi Arabia Received 4.11.2018, accepted 18.12.2018
Corresponding Author: Abdulrahman Sulaiman Alhazmi, E-mail: as.alhazmi@hotmail.com.

Gap in Care

Key Questions:

- Why was treatment not sought during this time?
- Did anyone discuss their symptoms with them (patient education)?
- Was the patient experiencing symptoms?
- Was the patient on prescription or OTC medications?
- Were any providers seen during this time, including massage therapy, etc.?
- Were there any changes in lifestyle or Activities of Daily Living during this time?

Fill the gap!

Document Reasons for Gap in Care in the History of Present Illness

ChiroArmor

Factors which may lead to complicating the recovery time…

- ✓**Nature of employment/work activities or ergonomics**
- ✓**Impairment/disability**
- ✓**Concurrent condition(s) and/or use of certain medications**
- ✓**History of prior treatment**
- ✓**Lifestyle habits** Lifestyle habits
- ✓**Psychological factors**

Document in the clinical record!

Chronic Prognostic Factors

- ✓Older age (pain and disability)
- ✓History of prior episodes (pain, activity limitation, disability)
- ✓Duration of current episode >1 month (activity limitation, disability)
- ✓Leg pain [for patients having LBP] (pain, activity limitation, disability)
- ✓Psychosocial factors [depression (pain); high fear-avoidance beliefs, poor coping 354 skills (activity limitation); expectations of recovery]
- ✓High pain intensity (activity limitation; disability)
- ✓Occupational factors [higher job physical or psychological demands (disability)]
- ✓Other factors or comorbidities not listed above may adversely affect a given patient's prognosis and management.

Document in the clinical record!

Documentation Requirements

What does Medicare Benefit Policy Guidelines have to say about how we need to document the care of the patient?

History
Examination
Clinical Decision Making

Initial Visit Documentation Requirements

Examination

Evidence-based approach

Examination

(ranging from problem focused to comprehensive)

- Vitals (necessary to rule out the underlying cause of the patient's complaint. Examples: headache / vertigo– hypertension, joint pain – infection/fever or loss of height – compression fracture)
- ROM specific to each region
- Orthopedic testing specific to each region
- Neurological findings
- Palpatory findings
- Imaging studies or other diagnostic studies including orders and report
- Examination includes functional assessment
- Appropriate Visceral or Central Nervous System evaluation when indicated

What other factors are involved?

Does the Mechanism of Injury Correlate with the Origin of Pain?

What do you include in your physical examination?

Physical Examination

Physical Examination

- Vitals
  - Blood Pressure
  - Pulse
  - Respiration
  - Height
  - Weight
  - BMI Calculation
- Postural
- Observation
- Focused Regional Evaluation
  - Orthopedic Tests
  - Neurological Tests
- Palpatory Findings
  - Segmental dysfunction
  - Myofascial
  - Pain/tenderness
  - Edema
- General Exam findings (pertinent to HPI, PFMSH, ROS, Vitals, etc.)

Examination Findings and Symptoms Correlation

Differentiate tissue involvement: Does it correlate to the mechanism of trauma?

Is the patient's **pain and symptoms reproduced** with testing of stressing the specific tissue involved?

Or is the pain reproduced through performing other tests or signs **during the physical exam**?

Red Flags
Immediate Referral

1. Fracture/dislocation
2. Cancer/tumor
3. Infection
4. Vertebrobasilar involvement
5. Instability (including degenerative, surgical, or rheumatoid etiologies)
6. Progressive scoliosis
7. Severe osteoporosis
8. Severe hypertension
9. Visceral pathology

Cautious Considerations

1. Osteoporosis
2. Congenitally blocked vertebrae
3. Rheumatoid arthritis
4. Seronegative arthropathies
5. Spinal stenosis
6. Spinal instability (i.e. listhesis)
7. A diagnosis of disc herniation or sequestration
8. Previous surgery
9. Use of corticosteroids or Cushing's disease
10. Use of anticoagulant medication
11. Psychiatric disorder
12. Previous adverse reaction to a specific therapy or therapeutic trial
13. Positive response to vertebrobasilar testing other than neurological (e.g. dizziness that is postural or cervicogenic)

Yellow Flag Behaviors

Two or more could suggest substance use disorder

- Deterioration in functioning at work or socially
- Illegal activities—selling medications, forging prescriptions, or buying medications from nonmedical sources
- Using medications in ways other than prescribed (e.g., injecting or snorting medication)
- Multiple reports of lost or stolen prescriptions
- Resistance to change in medications despite adverse effects
- Refusal to comply with random drug screens, call backs, or pill counts
- Concurrent abuse of alcohol or drugs Use of multiple physicians and pharmacies

Knowing When to Say When: Transitioning Patients from Opioid Therapy University of Massachusetts Medical School (Massachusetts Consortium) Jeff Baxter, M.D. April 2, 2014

Pain assessment through examination should include **determining the origin of pain** through tissue specific localization, orthopedic, neurological, biomechanical evaluation **leading to a differential diagnostic clinical decision-making** process.

Pain Assessment through Examination

Arriving at a diagnosis and Treatment Plan involves using Decision Support Tools, Critical Thinking

Processes, and an Evidence-informed Approach.

Medical Decision Making

Risk Factors with Strong Predictive Ability for developing chronic pain and disability

- Fear avoidance beliefs
- Catastrophizing
- Somatization
- Depressed mood
- Distress and anxiety
- Early disability or decreased function
- High initial pain levels
- Increased age
- Poor general health status
- Non-organic signs
- Secondary gain (occupational, social, family, financial)

Differential Diagnosis

Medicare Documentation

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned are required, one of which must be **asymmetry/misalignment** or **range of motion abnormality**.

Medical Necessity

Medical necessity is defined as services that are **reasonable and necessary** for the diagnosis or treatment of an illness or injury or to **improve the functioning** of a malformed body member and are not excluded under another provision of the Medicare Program.

Demonstrating a Subluxation

P.A.R.T

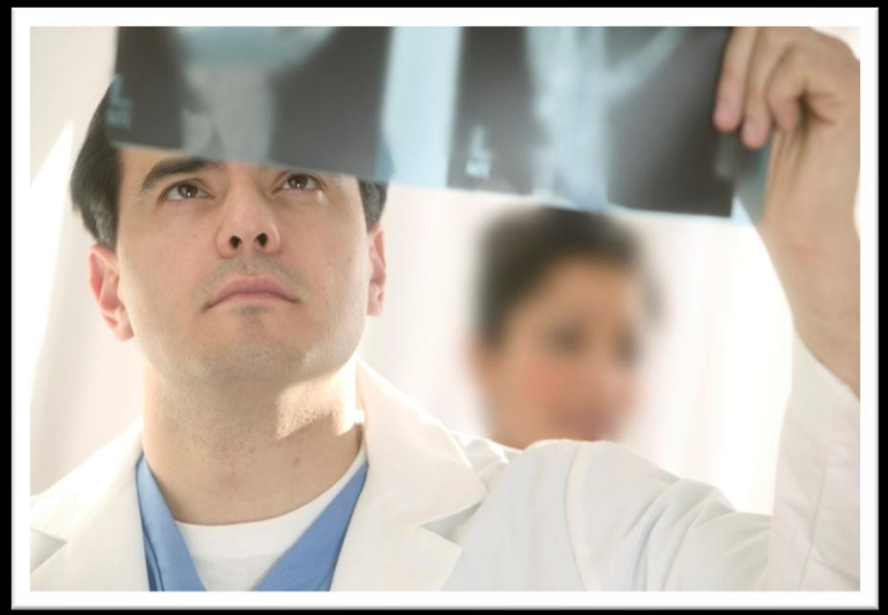
Diagnostic Imaging

Initial Visit Medicare Requirement

Location of Subluxation

The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine

Documentation of Subluxation



Subluxation may be demonstrated by:

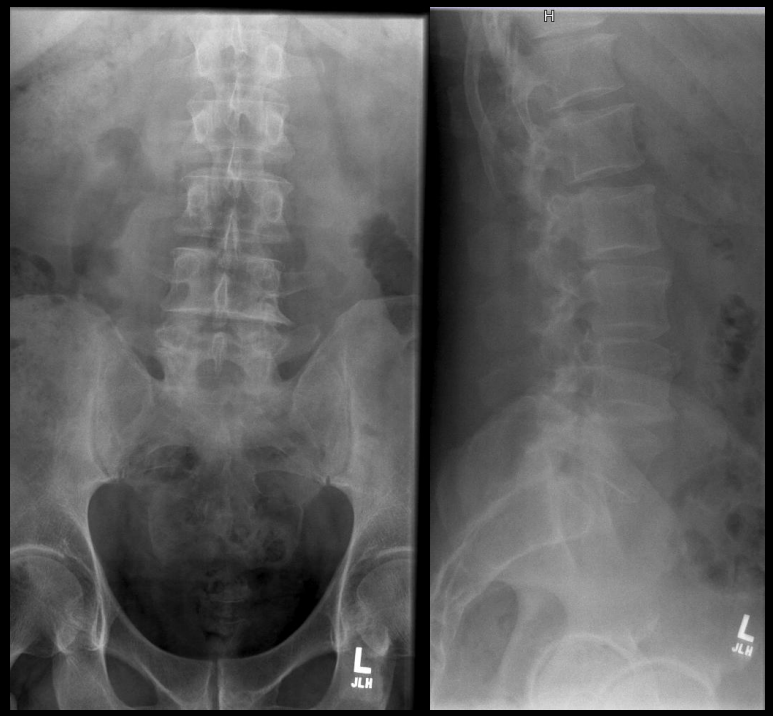
- ✓X-ray
- ✓Physical Examination

Subluxation Demonstrated by X-Ray

The x-ray analysis to demonstrate subluxation must be taken at **a time reasonably proximate** to the initiation of a course of treatment.

An x-ray is considered reasonably proximate if it was taken **no more than 12 months prior to or 3 months following the initiation** of a course of chiropractic treatment.

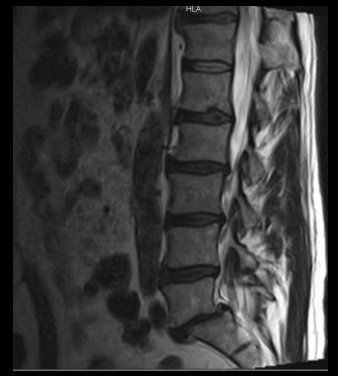
Subluxation Demonstrated by X-Ray



In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted, provided 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**.

Subluxation Demonstrated by CT or MRI

A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.



P.A.R.T.

P: Pain
A: Asymmetry/misalignment
R: Range of Motion
T: Tissue & Tone changes

Must have 2 of the 4 above &
A or R has to be documented

Pain/Tenderness

Pain & Tenderness are evaluated in terms of location, quality, frequency, and intensity.

Pain/Tenderness

Pain and tenderness findings may be identified through one or more of the following:

- **Observation**
- **Percussion**
- **Palpation**
- **Provocation**

Pain/Tenderness

Pain intensity may be assessed using one or more of the following:

- **Visual Analog or Numeric Rating Scales**
- **Algometers**
- **Pain Questionnaires**

Asymmetry/Misalignment

Asymmetry/Misalignment may be identified through one or more of the following:

- Observation (posture and gait analysis)
- Static Palpation
- Diagnostic Imaging

Range of Motion Abnormality

Range of motion abnormalities may be identified through one or more of the following:

- Motion Palpation
- Observation
- Stress diagnostic imaging
- Range of Motion Measurements

Tissue/Tone

Tissue and or tone texture may be identified through one or more of the following procedures:

- Observation
- Palpation
- Use of Instruments
- Tests for Length and Strength

Documentation of Subluxation Objective & Procedure Section of the note

There are two ways in which the level of the subluxation may be specified in patient's record.

The exact bones may be listed, for example: C 5, 6, etc.

The area may suffice if it implies only certain bones such as: occipito-atlantal (occiput and CI (atlas)), lumbo-sacral (L5 and Sacrum) sacro-iliac (sacrum and ilium).

ChiroArmor

Informed Consent

What is a valid informed consent?

Paper that a patient signs during the initial intake process?

How often are you required to obtain an informed consent from the patient?

State’s Informed consent laws

Informed Consent

Prior to diagnostic and/or treatment procedures.

Informed Consent

…it's all about using a valid form AND the Process…

Consent by a person to undergo a medical procedure, participate in a clinical trial, or be counseled by a professional such as a social worker or lawyer, after receiving all material information regarding risks, benefits, and alternatives.

informed consent. (n.d.) *The American Heritage® Medical Dictionary*. (2007). Retrieved May 26 2020 from https://medical-dictionary.thefreedictionary.com/informed+consent

Patient Safety
Informed Consent

Standard of Care

- Reasonable Patient standard
- Reasonable Physician standard
- Reasonable Chiropractic Standard (Wisconsin)

Reasonable Patient Standard

The standard is whether a reasonable patient would have considered the information sufficient to make an informed decision

Reasonable Physician Standard

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

WISCONSIN ONLY

Reasonable Chiropractic Standard

- Only found in Wisconsin
- Based on what a reasonable chiropractor would disclose
- Difficult for MD/DO to testify against Chiropractors

Six Key Elements

For the patient's consent to be valid, the DC needs to review the following six elements

1. The patient's diagnosis/condition and the proposed treatment, modality or procedures for correction.
2. The relevant risks and benefits of the proposed treatment, modality or procedures
3. Alternative treatment or procedures that are available to the patient and the relative risk, benefits, and uncertainties related to each alternative;
4. The risk and benefits of not receiving or undergoing any treatment procedure
5. The assessment of the patients understanding of the information provided (decision making capacity)
6. The acceptance by the patient to undergo the recommended treatment, modality or procedure.

Informed Consent: Risks & Alternative Methods

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.

Informed Consent: Risks & Alternative Methods

Sard v Hardy 1977

- There was no breach of duty 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 the physician does not substitute their judgement, no matter how appropriate, for that of the patient.

Informed Consent

Sard v Hardy
1977

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.

Informed Consent

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's defense was that ***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***.

Informed Consent: Material Changes

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.

Informed Consent Process

Informing patients properly depends upon the sequence and information provided to disclose material risk.

Informed Consent

Prior to diagnostic and/or treatment procedures.

Discussion between the Clinician and the Patient

Obtain the patient's informed consent to the procedures **after** they have been provided material information **and** discussion with the doctor about all of the alternatives or risks of care.

Informed Consent Process

PROCEDURE:

1. Upon patient's check-in, staff provides the unsigned Informed Consent form to the patient following taking the patient's history.
2. Informed Consent is reviewed and discussed with the patient **BY THE CLINICIAN**, at the time of visit, immediately after health history and exam and **prior to treatment and diagnostic procedures**. Any questions the patient may have are answered, always by the clinician.
3. Patient signs and dates form; clinician signs and dates form;
4. Completed form gets turned in to the front desk and gets scanned into patient record – or is signed within the EHR system records directly.

When do we use Informed Consent?

Every new patient and those patients who are re-admitted for care due to a new injury or condition, etc.

New Patient/Re-Admit

New Diagnosis

A new diagnosis for the patient represents a material change for the patient.

New evidence regarding treatment and/or procedures may represent a material change for the patient for consideration of alternative treatment or procedures. New risks for specific treatments/procedures should be updated in the informed consent form as well.

New Evidence

A change in the use of a procedure in the care of the patient regardless of a change in the diagnosis.

New Treatment Procedure

Informed Consent **must be obtained annually** and with new patients as part of the intake procedure and/or upon **re-admit, new diagnosis, new evidence, or new treatment**.

Informed Consent Process

NCMIC
Insurance Company

14001 University Avenue, Clive, Iowa 50325-8258
Local: 515-313-4500 Toll-Free: 800-247-8043
Claims Reporting Line: 800-242-4062

Dear Doctor:

NCMIC does not have any position regarding informed consent. As an insurer, we deal with each insured and the malpractice claim against them on an individual basis. If NCMIC had such views or guidelines it could prove detrimental to other insureds and their claims.

As for the consent form itself, we have always maintained the policy that we do not review any individual consent forms nor will we draft an informed consent form for doctors to use in their practices. Further, we do not endorse any form for use by the chiropractic profession.

Doctors need to understand that informed consent is a process, which may or may not be satisfied with a written form. It is the doctor's responsibility to make sure that the patient is properly informed, understands and consents to the treatment to be provided; however, it is also within the doctor's discretion as to how the information is communicated and how the consent is obtained.

Generally, the legal concept of informed consent arises from the principle that absent extenuating circumstances, a patient has the right to exercise control over his or her body by making an informed decision concerning whether to consent to a particular course of treatment or procedure. For the patient to truly consent it is generally held that they should know and completely understand the following:

1) Nature of the treatment to be rendered;
2) All material risks attendant to that treatment;
3) The possibility of an occurrence of the aforenoted risks;
4) Alternative treatment available and the risks attendant to those treatments;
5) The consequences of allowing the condition to remain untreated.

Even though the principles stated above have been generally well accepted throughout the country, specific state statutes or state case law often further define the necessary elements to establish informed consent.

Because of the possible peculiarities in any given state, we believe that doctors of chiropractic would be best served by contacting an attorney in their state who practices health care related law and ask that person to advise the doctor regarding their particular practice. In this way, the doctor will have the benefit of an attorney who should be current on the informed consent issue in that state. The attorney can advise the doctor whether there are any specific informed consent laws which might impact that doctor's practice and whether use of an informed consent form would be prudent. Attached is sample language that may be considered should you choose to use a form to supplement the informed consent process.

From our experience, when a health care provider gets sued for malpractice, often times an allegation is made that there was no informed consent given by the patient. Again, NCMIC maintains no position on this issue, but rather, leaves the decision up to the practitioner.

I hope this information is helpful.

Informed Consent Form

https://www.ncmic.com/insurance/malpractice/practice-and-policy-forms/

Six Exceptions

(1) Detailed technical information that in all probability a patient would not understand.

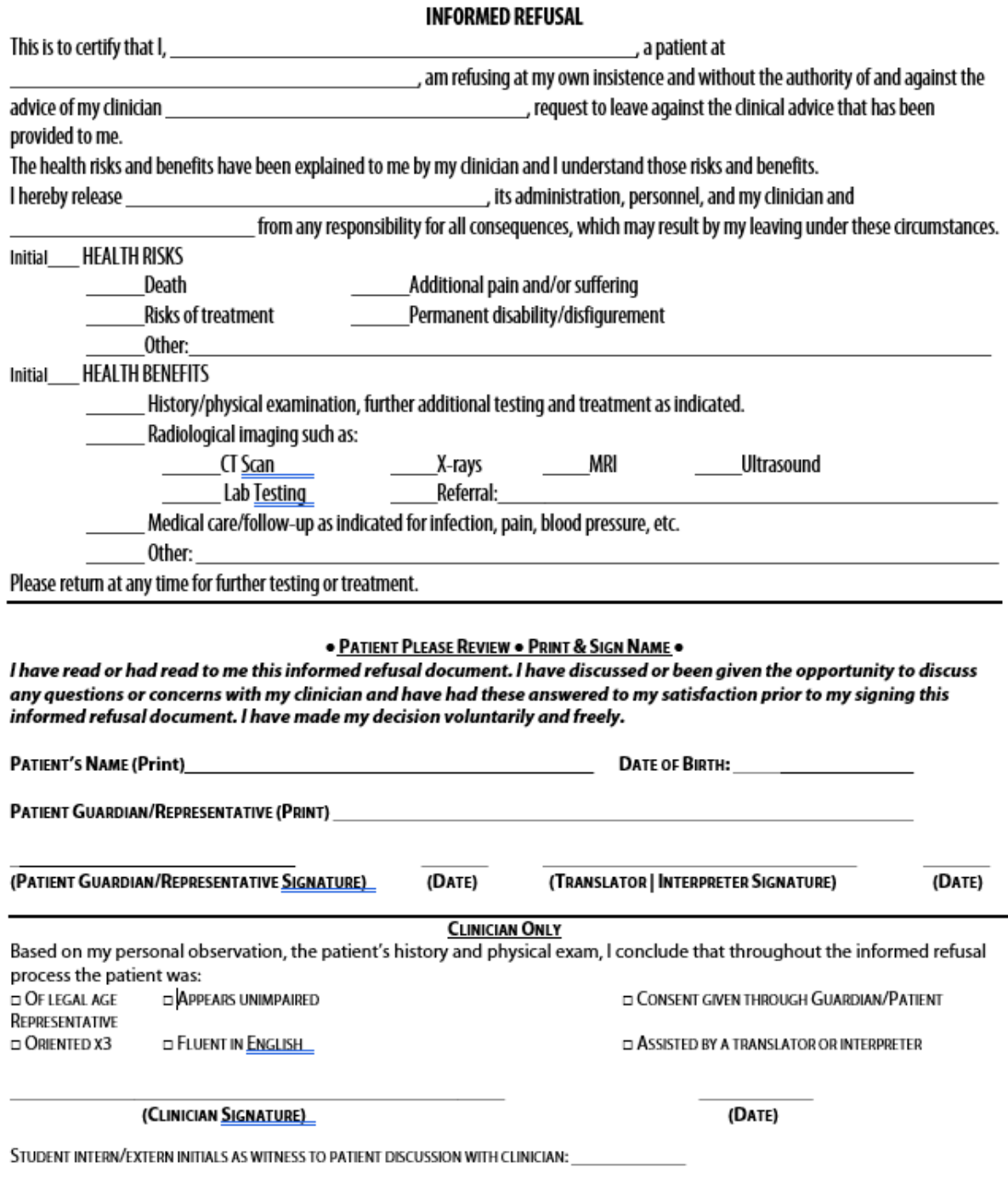
(2) Risks apparent or known to the patient.

(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.



INFORMED REFUSAL

This is to certify that I, _____, a patient at _____, am refusing at my own insistence and without the authority of and against the advice of my clinician _____, request to leave against the clinical advice that has been provided to me.

The health risks and benefits have been explained to me by my clinician and I understand those risks and benefits.

I hereby release _____, its administration, personnel, and my clinician and _____ from any responsibility for all consequences, which may result by my leaving under these circumstances.

Initial___ HEALTH RISKS

_____Death _____Additional pain and/or suffering

_____Risks of treatment _____Permanent disability/disfigurement

_____Other:_____

Initial___ HEALTH BENEFITS

_____ History/physical examination, further additional testing and treatment as indicated.

_____ Radiological imaging such as:

_____CT Scan _____X-rays _____MRI _____Ultrasound

_____ Lab Testing _____Referral:_____

_____ Medical care/follow-up as indicated for infection, pain, blood pressure, etc.

_____ Other: _____

Please return at any time for further testing or treatment.

• PATIENT PLEASE REVIEW • PRINT & SIGN NAME •

I have read or had read to me this informed refusal document. I have discussed or been given the opportunity to discuss any questions or concerns with my clinician and have had these answered to my satisfaction prior to my signing this informed refusal document. I have made my decision voluntarily and freely.

PATIENT'S NAME (Print)_____ DATE OF BIRTH: _____

PATIENT GUARDIAN/REPRESENTATIVE (PRINT) _____

_____ _____ _____ _____

(PATIENT GUARDIAN/REPRESENTATIVE SIGNATURE) (DATE) (TRANSLATOR | INTERPRETER SIGNATURE) (DATE)

CLINICIAN ONLY

Based on my personal observation, the patient's history and physical exam, I conclude that throughout the informed refusal process the patient was:

□ OF LEGAL AGE □ APPEARS UNIMPAIRED □ CONSENT GIVEN THROUGH GUARDIAN/PATIENT REPRESENTATIVE

□ ORIENTED X3 □ FLUENT IN ENGLISH □ ASSISTED BY A TRANSLATOR OR INTERPRETER

_____ _____

(CLINICIAN SIGNATURE) (DATE)

STUDENT INTERN/EXTERN INITIALS AS WITNESS TO PATIENT DISCUSSION WITH CLINICIAN: _____

Informed Refusal

If the patient refuses care or the clinical advice provided, have the patient sign an "Informed Refusal" form, which should provide full disclosure of all possible risks of refusing clinical services and advice before leaving the clinic.

Review your informed consent

Checklist for Assessing the Informed Consent Form

Does the Informed Consent Form contain the following required elements?

(If no, add needed content on line below)

Yes	No	
❑	❑	The name/nature and purpose of a proposed treatment or procedure
❑	❑	The benefits of proposed treatment or procedures
❑	❑	The risks of proposed treatment or procedures
❑	❑	Alternatives (regardless of costs or extent covered by insurance)
❑	❑	The risks and benefits of alternatives
❑	❑	The risks and benefits of not receiving treatments or undergoing procedures

Does the Form contain details (or space for) the following content?

Yes	No	
❑	❑	Name and signature of the patient, or if appropriate, legal guardian.
❑	❑	Name of all practitioners performing the procedure and individual significant task if more than one practitioner.
❑	❑	Date and time consent is obtained.
❑	❑	Statement that procedure was explained to patient or guardian.
❑	❑	Space to document that patient is unable to speak English.
❑	❑	Space for documentation of interpretive services (on site, telephonic, video) and/or of sight translation of form.
❑	❑	Signature of professional person witnessing the consent; and
❑	❑	Name and signature of person who explained the procedure to the patient or guardian.

Other comments, questions, or suggestions you have about the informed consent form:

ClinicArmor, LLC © 2021

POLICY RECOMMENDATION

Informed Consent documents must be reviewed annually and with new patients as part of the intake procedure and upon re-admit, new diagnosis, or new injury. After direct discussion with the patient, the Provider and patient will sign and date the form.

Informed Consent Process

Clinical Decision Making

(Must be supported by the clinical findings)

- Diagnosis
- Treatment plan: Goals, Duration, and Frequency (measurable and medically necessary)
- Treatment plan includes self-care instructions and active care recommendations.

Diagnosis Coding

Initial Visit

Coding Sequencing and Hierarchy

- Must be done in this order
- Correct Coding
- Follow LCD of your Medicare carrier

National Coverage Determinations and Local Coverage Determinations

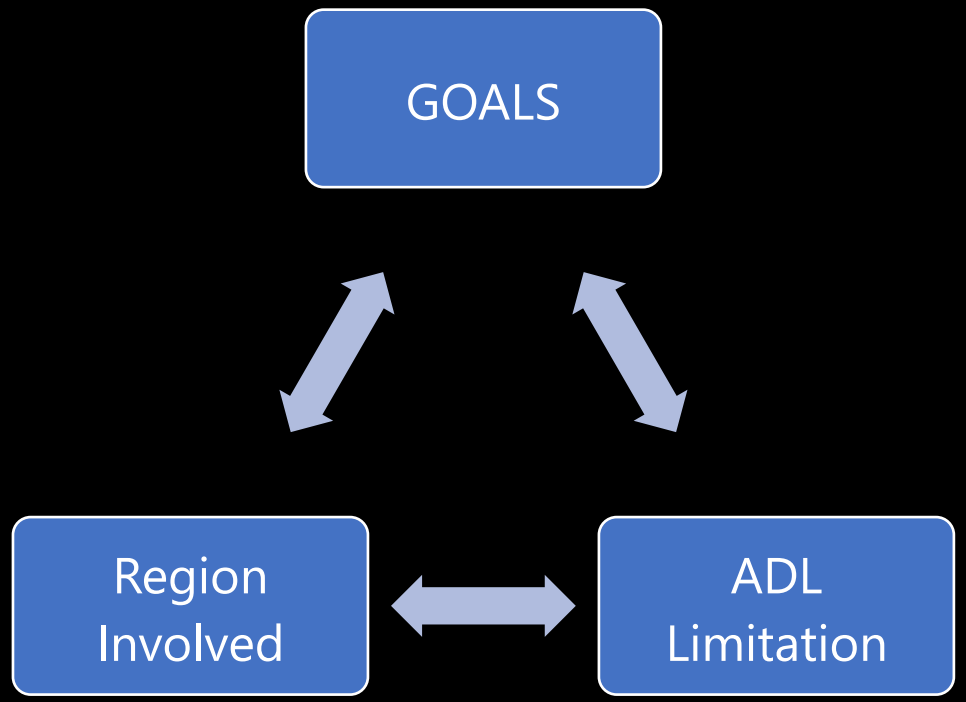
National Coverage Determinations (NCD) explain when Medicare will pay for items or services. Each Medicare Administrative Contractor (MAC) is responsible for interpreting national policies into regional policies, called Local Coverage Determinations (LCD). LCDs further define what codes are needed and when an item or service will be covered. LCDs have jurisdiction only within their region.

Medicare Coding Hierarchy

- Segmental Dysfunction Codes (M99.01-M99.05)
- Neurological
- Segmental Dysfunction Codes (M99.01-M99.05)
- Primary Structural
- Segmental Dysfunction Codes (M99.01-M99.05)
- Soft-Tissue
- Segmental Dysfunction Codes (M99.01-M99.05)
- Pain (Watch out for Excludes: 1)

Treatment Plan

Treatment Plan



Specific Measurable Goals

(Establish objective end point targets that can be measured to see if you actually reach your goal)

Duration of Care

Total Frequency of Care

Begin with the Pre-Incident Status as the benchmark for your goal.

What level of improvement do you expect to achieve?

Establishing Pre-incident Status

ADL, VAS, outcome tool values established prior to the condition.

Progress Evaluations

Discharge from care when goals have been achieved.

Commonly used chiropractic goals…

Reduce	Reduce pain
Increase	Increase Function
Increase	Increase range of motion
Decrease	Decrease overall % on Oswestry
Decrease	Decrease pain from severe to moderate

Specific goals vs Generalized goals

- Mild, Moderate, severe vs **quantifiable numbers.**
- "Reduce pain" vs "**achieve change from 8 to a 5** pain scale rating on VAS".

Goal Selection

✓Correlate to the **mechanism of trauma** and patient's symptoms.

✓Correlate to the initial **start point** and specific desired **end point**.

✓Correlate goal to **pre-incident status**.

Pre-incident Status is the benchmark until or unless therapeutic gain has plateaued.

Specific measurable goals are based on the benchmark established as the maximum level of improvement

EXAMPLE

Prior to onset of condition, the patient did not experience neck pain and could turn his head to the right without restrictions. Patient notes that due the neck pain he can only sleep one hour without waking up. Current cervical ROM to right is 25 degrees and a pain scale rating of 8 was noted.

ChiroArmor

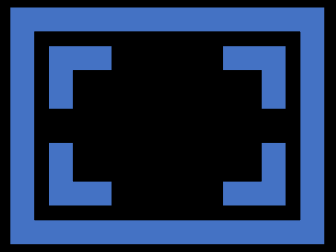
Generalized vs. Specific Goal Comparison

Goals:

- **Patient will be seen 3x a week for 4 weeks to decrease pain, increase ROM and cervical function.**

Goals:

- **Sleep 5 hours without waking up (ADL)**
- **Decrease VAS from 8 to 4**
- **Increase cervical rotational ROM to the right from 25 to 50 degrees.**
- **Duration to achieve goal will be 4 weeks at a frequency of 3x a week.**

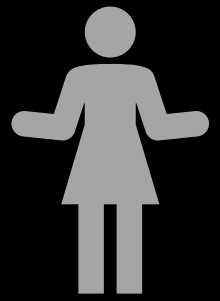


Quantifiable and Measurable

P.S. Always ask yourself, “What’s the number?”

Goal Categories

PAIN GOAL



ACTIVITY OF DAILY LIVING
(SPECIFIC FUNCTIONS)

RANGE OF MOTION

DURATION OF CARE

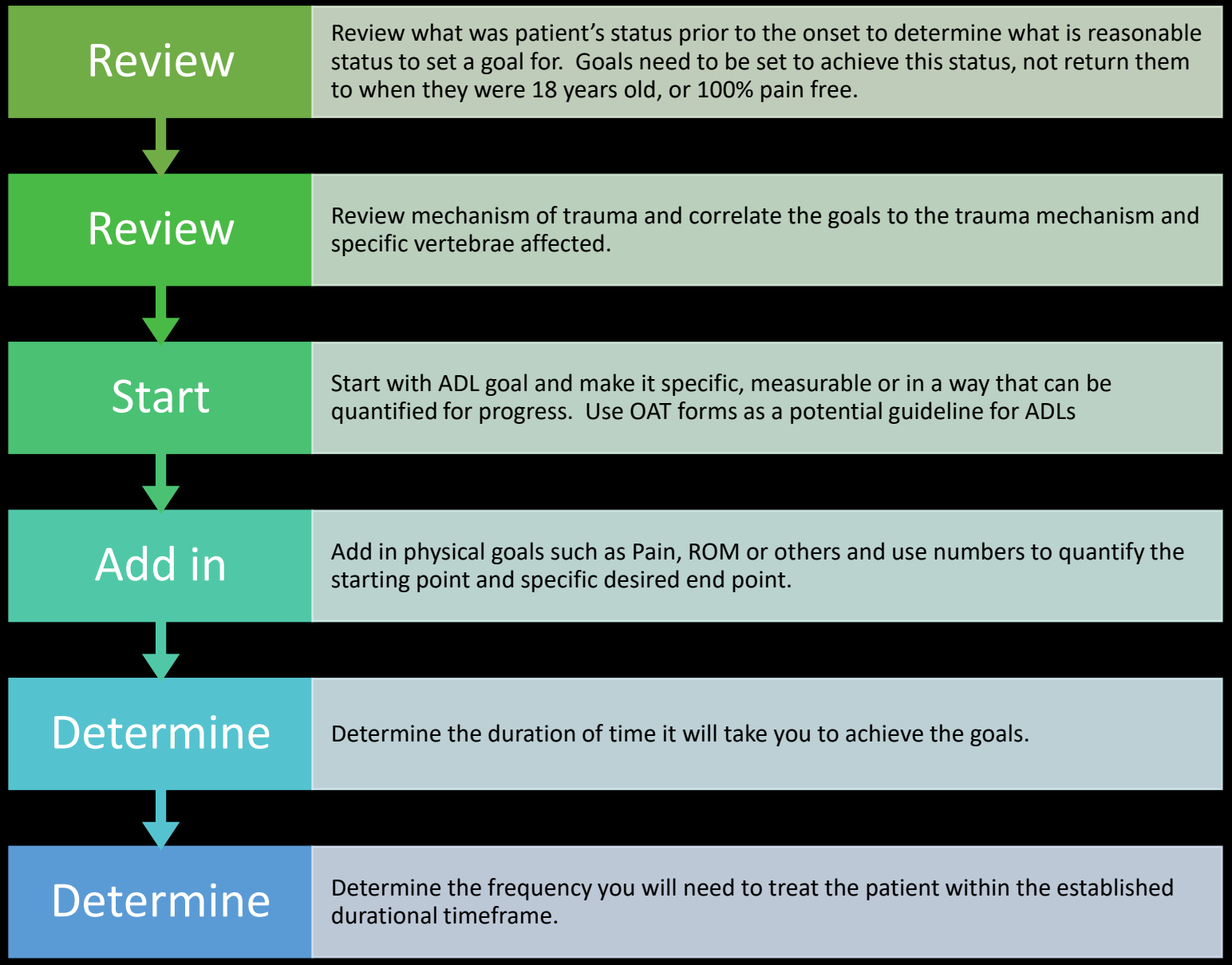
How long will it take to achieve the specific measurable goals and return the patient to pre-incident status – or reach MTB?

Once the goal(s) have been chosen, then **determine the duration** it will take to accomplish the goal (**end of care**).

How many visits will you need to achieve the specific measurable goals within the already determined duration?

FREQUENCY OF CARE

Treatment Plan Goal Summary



Barriers to Care

Does the exacerbation or issue amend the current goals/duration predicted or does it require a re-evaluation with a new initial visit documentation / treatment plan?

Factors which may lead to complicating the recovery time…

- ✓ **Nature of employment/work activities or ergonomics** The nature and psychosocial aspects of a patient's employment must be considered when evaluating the need for ongoing care (e.g. prolonged standing posture, high loads, and extended muscle activity).
- ✓ **Impairment/disability** The patient who has reached MTB, but has failed to reach pre-injury status has an impairment/disability even if the injured patient has not yet received a permanent impairment/disability award.
- ✓ **Concurrent condition(s)** and/or use of certain medications may affect outcomes.
- ✓ **History of prior treatment** Initial and subsequent care (type and duration), as well as patient compliance and response to care, can assist the physician in developing appropriate treatment planning. Delays in the initiation of appropriate care may complicate the patient's condition and extend recovery time.
- ✓ **Lifestyle habits** Lifestyle habits may impact the magnitude of treatment response, including outcomes at MTB.
- ✓ **Psychological factors** A history of depression, anxiety, somatoform disorder or other psychopathology may complicate treatment and/or recovery.

Document in the clinical record!

Chronic Prognostic Factors

- ✓Older age (pain and disability)
- ✓History of prior episodes (pain, activity limitation, disability)
- ✓Duration of current episode >1 month (activity limitation, disability)
- ✓Leg pain [for patients having LBP] (pain, activity limitation, disability)
- ✓Psychosocial factors [depression (pain); high fear-avoidance beliefs, poor coping 354 skills (activity limitation); expectations of recovery]
- ✓High pain intensity (activity limitation; disability)
- ✓Occupational factors [higher job physical or psychological demands (disability)]
- ✓Other factors or comorbidities not listed above may adversely affect a given patient's prognosis and management.

Document in the clinical record!

Aggravation vs. Exacerbation

What's the difference?

When an injury or incident creates, worsens, or combines with a preexisting condition to create a new and greater disability.

Aggravation

https://definitions.uslegal.com/a/aggravation-rule/

Exacerbation

An increase in the severity of a disease or its signs or symptoms; a natural progression of the condition.

(throwing gas on a fire)

Documentation Requirements: Subsequent Visits

1. History:
   - Review of chief complaint; Always discuss the symptoms associated with the chief complaint.
   - “Changes since last visit” are good key words to have in your documentation.
   - Monitor the pain level goals in this section. If using the VAS system, it is positive to note the numerical changes in this section.
   - Encounter Specific!

Documentation Requirements: Subsequent Visits

2. Physical exam

- Exam of area of spine involved in diagnosis; The exam is based on the CMT level exam not an EM level examination.
- Assessment of change in patient condition since last visit;
- Evaluation of treatment effectiveness. (functional goal improvement)
- Monitor and specifically note the progress involved in the ADL goals that were set in the initial visit treatment plan.

Documentation Requirements: Subsequent Visits

Key points for Subsequent visits:

- Primarily a therapeutic visit
- Continue to compare the current visit to the last visit
- Review and comment on the progress of the specific measurable goals created in the treatment plan

How do we demonstrate treatment effectiveness?

Quantify and Measure

Update Subjective Pain Intensity and Function on Each Visit

Subjective
Changes since the last visit…

- Pain Level using VAS
- Aggravating Factors
- ADL Limitation

How do we demonstrate treatment effectiveness?

Progress Evaluations

Compare previous history and examination findings

Re-assess patient's progress towards goals and treatment plan

Update the patient on progress with a report of findings

ChiroArmor

Beyond Active Treatment

Care management and documentation for enhancing human performance.

Have the goals been achieved for the episode of care?

Or has the patient reached a plateau in therapeutic gains and/or human performance?

Maintenance Therapy

Maintenance therapy is defined as a treatment plan that seeks to **prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to 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. For information on how to indicate on a claim a treatment is or is not maintenance, see §240.1.3.

Supportive Care

Supportive care is long-term, interval-based treatment for patients who have achieved maximum therapeutic benefit but experience deterioration when treatment is stopped. **Its purpose is to maintain a level of function and prevent deterioration in chronic or recurrent conditions.**

Unlike routine maintenance, supportive care is often **"as-needed" in response to symptomatic decline and is appropriate when a trial of withdrawing care has failed.** Similar to maintenance care, it is generally not covered by traditional Medicare when it's supportive rather than corrective.

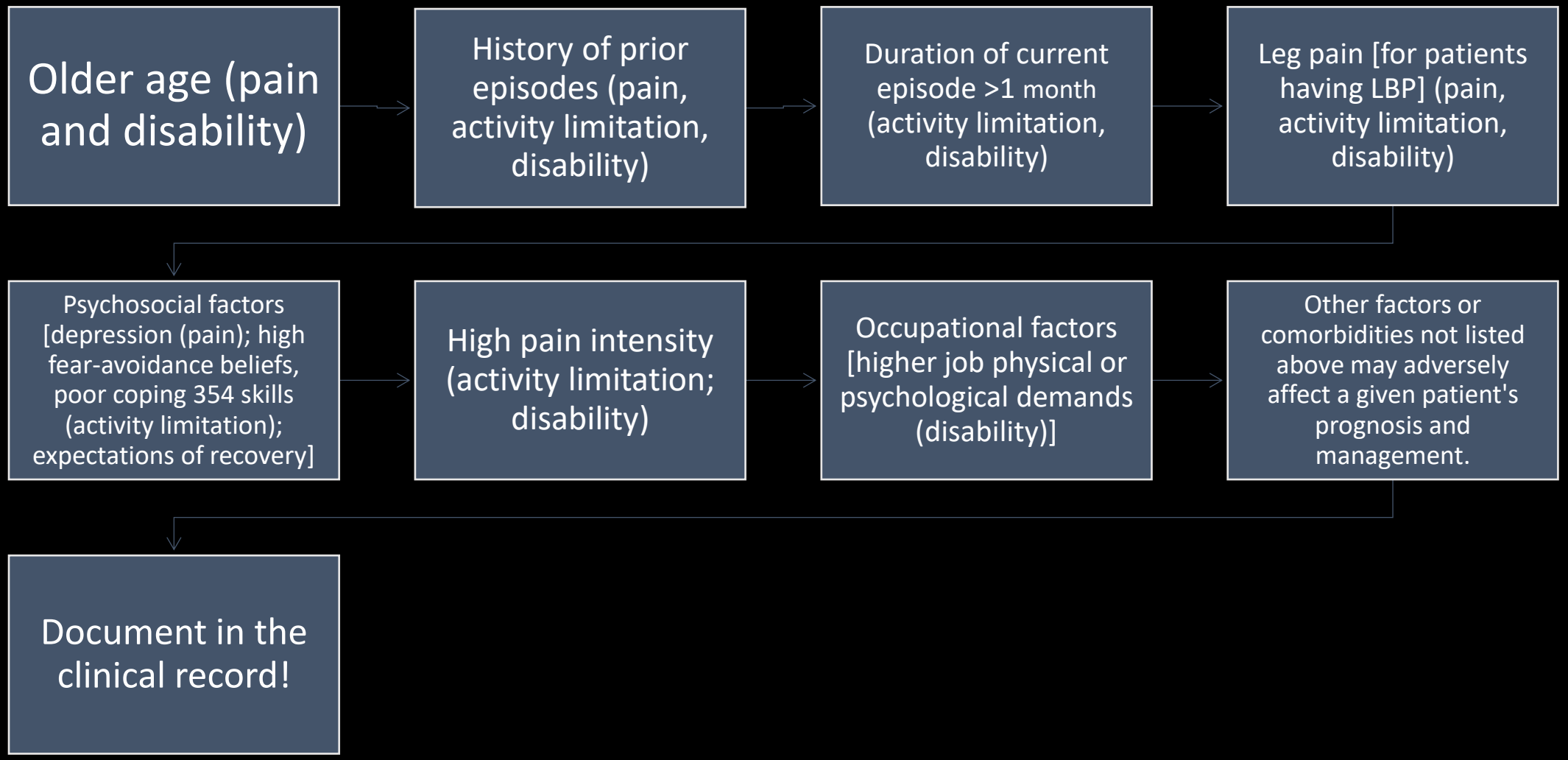
What happens when the patient's progress reaches a plateau?

Maintenance / Supportive Care begins…

Clinical Practice Guideline: Chiropractic Care for Low Back Pain Globe, Gary et al. Journal of Manipulative & Physiological Therapeutics, Volume 39, Issue 1, 1 - 22

Maintenance / Supportive Care

Chronic Prognostic Factors



Factors which may lead to complicating the recovery time…

- ✓**Nature of employment/work activities or ergonomics** The nature and psychosocial aspects of a patient's employment must be considered when evaluating the need for ongoing care (e.g. prolonged standing posture, high loads, and extended muscle activity).
- ✓**Impairment/disability** The patient who has reached MTB, but has failed to reach pre-injury status has an impairment/disability even if the injured patient has not yet received a permanent impairment/disability award.
- ✓**Concurrent condition(s)** and/or use of certain medications may affect outcomes.
- ✓**History of prior treatment** Initial and subsequent care (type and duration), as well as patient compliance and response to care, can assist the physician in developing appropriate treatment planning. Delays in the initiation of appropriate care may complicate the patient's condition and extend recovery time.
- ✓**Lifestyle habits** Lifestyle habits may impact the magnitude of treatment response, including outcomes at MTB.
- ✓**Psychological factors** A history of depression, anxiety, somatoform disorder or other psychopathology may complicate treatment and/or recovery.

Document in the clinical record!

Trial of therapeutic withdrawal may begin…

Patient may be released on a PRN basis with instructions on self-care management and/or reduced in frequency of care and monitored for regression of condition over a six months timeframe.

Maintenance/Supportive Care Management

Those patients with chronic pain may vary in their need for intervention. Self-care management is a foundational element in their care plan. Chronic pain management may be:

- Self-care management only
- Active treatment for aggravations or exacerbations leading to episodic care
- Ongoing "scheduled" care for those chronic pain sufferers who have a predictable need for care prescribed at specific times validated through a trial of withdrawl that demonstrated

Regression of the Condition

When pain and/or ADL dysfunction exceeds the patient's ability to self-manage, the medical necessity of care should be documented and the chronic care treatment plan altered appropriately.

Clinical Practice Guideline: Chiropractic Care for Low Back Pain Globe, Gary et al. Journal of Manipulative & Physiological Therapeutics, Volume 39, Issue 1, 1 - 22

Key clinical questions for care plan decision making…

Can the patient manage through the regression on his/her own?

Will the condition need episodic care to bring back MTB?

Has the condition deteriorated enough that normal daily activities cause regression of the maximum therapeutic benefit over time – necessitating prescribed and timely ongoing care?

Final Evaluation (Six months or prior)

Following the six months trial of therapeutic withdrawal the patient returns for a final evaluation to verify if a maximum therapeutic benefit has been sustained.

The findings of the evaluation will determine course of management including self-management or the need for future chiropractic care (episodic or ongoing) to retain the benefits achieved; if regression of the condition has been confirmed.

Maintenance/Supportive Care Management Plan (Purpose)

Preventing relapse and/or exacerbations of the original complaint(s) as well as associated comorbidities thereby sustaining the patient's maximum therapeutic benefit.

Maintenance/Supportive Care Management

Patient specific goals:

- Consisting of the pain, activity, range of motion goals which have been previously determined as the **benchmark of the maximum therapeutic benefit** for the patient's condition.

Frequency and Duration of care:

- Dependent upon whether the care is episodic or ongoing.
  - If episodic care is required, then the frequency and duration will be conducted through a trial of care.
  - If the care is ongoing, then the **frequency determined to be necessary is based upon the regression experience** from therapeutic withdrawal which will inform the treatment prescription.

Algorithms for Spine-related Pain

Algorithms for the Chiropractic Management of Acute and Chronic Spine-Related Pain

Clinical Practice Guideline: Chiropractic Care for Low Back Pain. Gary Globe, PhD, MBA, DC, Ronald J. Farabaugh, DC, Cheryl Hawk, DC, PhD, Craig E. Morris, DC, Greg Baker, DC, Wayne M. Whalen, DC, Sheryl Walters, MLS, Martha Kaeser, DC, MA, Mark Dehen, DC, Thomas Augat, DC. Journal of Manipulative & Physiological Therapeutics. Volume 39, Issue 1, Pages 1-22 (January 2016) DOI: 10.1016/j.jmpt.2015.10.006

How should maintenance or wellbeing care be documented?

Consider your level of maximum therapeutic benefit as determined with functional parameters and metrics to be your end-goal to achieve and maintain human performance.

Medicare Policy Compliance

- PART I: Compliance Program Requirements
- PART II: Enrollment and Participation
- **PART III: Federal Health Care Regulations**
- PART IV: Medicare Documentation Requirements

PART III
Federal Health Care Regulations

Understanding how business decisions may impact compliance to federal and/or state law.

The Difference Between "Erroneous" and "Fraudulent" Claims To Federal Health Programs

Fraudulent

False Claims Act, covers offenses that are committed with actual knowledge of the falsity of the claim, reckless disregard, or deliberate ignorance of the falsity of the claim.

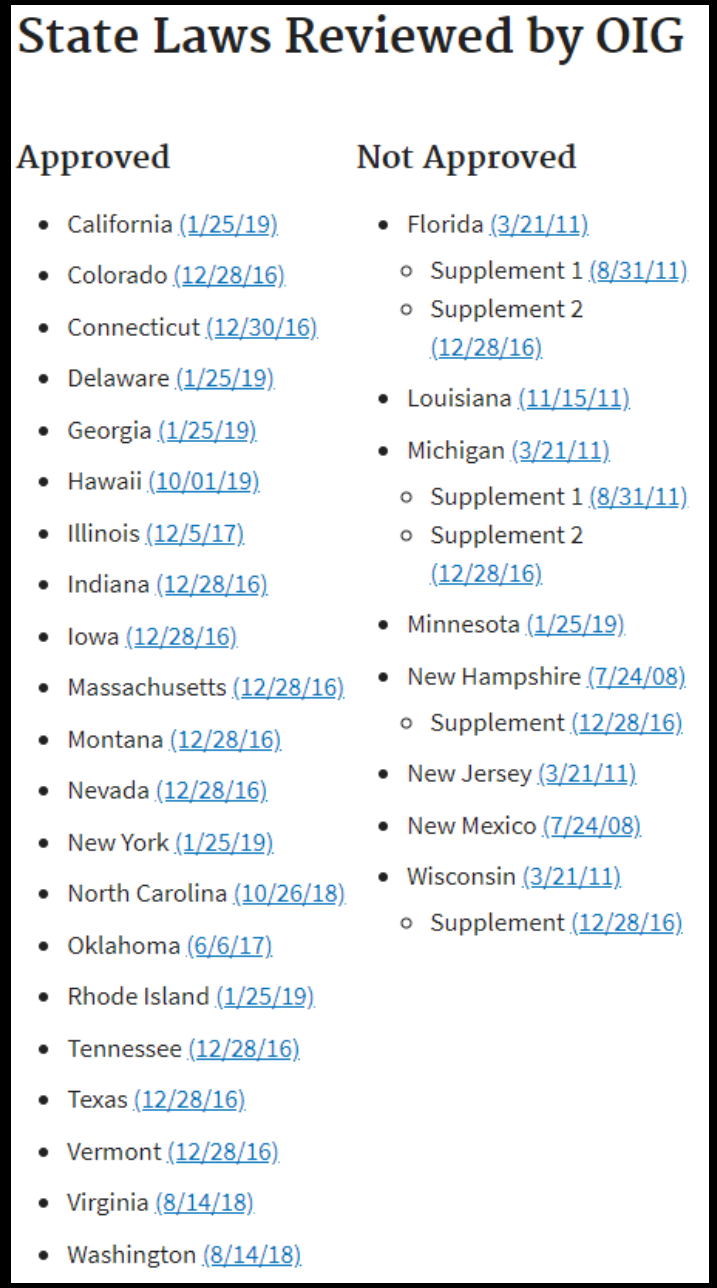
Erroneous

The False Claims Act does not encompass mistakes, errors, or negligence.

False Claims Act

False Claims Act

The Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government.



State Laws Reviewed by OIG

Approved

- California (1/25/19)
- Colorado (12/28/16)
- Connecticut (12/30/16)
- Delaware (1/25/19)
- Georgia (1/25/19)
- Hawaii (10/01/19)
- Illinois (12/5/17)
- Indiana (12/28/16)
- Iowa (12/28/16)
- Massachusetts (12/28/16)
- Montana (12/28/16)
- Nevada (12/28/16)
- New York (1/25/19)
- North Carolina (10/26/18)
- Oklahoma (6/6/17)
- Rhode Island (1/25/19)
- Tennessee (12/28/16)
- Texas (12/28/16)
- Vermont (12/28/16)
- Virginia (8/14/18)
- Washington (8/14/18)

Not Approved

- Florida (3/21/11)
  - Supplement 1 (8/31/11)
  - Supplement 2 (12/28/16)
- Louisiana (11/15/11)
- Michigan (3/21/11)
  - Supplement 1 (8/31/11)
  - Supplement 2 (12/28/16)
- Minnesota (1/25/19)
- New Hampshire (7/24/08)
  - Supplement (12/28/16)
- New Jersey (3/21/11)
- New Mexico (7/24/08)
- Wisconsin (3/21/11)
  - Supplement (12/28/16)

State False Claims Act Reviews

The Office of Inspector General (OIG), in consultation with the Attorney General, determines whether States have false claims acts that qualify for an incentive under section 1909 of the Social Security Act. Those States deemed to have qualifying laws receive a 10-percentage-point increase in their share of any amounts recovered under such laws.

False Claims Act

The Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government.

Inducement

The term “induce” has been defined as follows: to bring on or about, to affect, cause, to influence to an act or course of conduct, lead by persuasion or reasoning, incite by motives, prevail on.

Black’s Law Dictionary, 697 (6th ed. 1990).

Inducement

The case of *Hanlester Network v. Shalala*, 51 F.3d 1390, 1398 (9th Cir. 1995) involved an appeal from a decision of an ALJ that defendants had violated Medicare and Medicaid anti-kickback provisions.

The Secretary determined that the phrase “to induce” in § 1128B(b)(2) of the Act connotes “an intent to exercise influence over the reason or judgment of another in an effort to cause the referral of program-related business”. We agree with this interpretation. (id at 1398.)

Questions to ask yourself…

ChiroArmor

Does the business arrangement involve offering, paying, soliciting, or receiving any renumeration (i.e., anything of value) to induce or reward referrals of items or services reimbursable by a federal health care program?

Anti-Kickback

Anti-Kickback

Does the business arrangement involve giving something of value to a Medicare or Medicaid beneficiary that will likely influence the beneficiary's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicare or a state health care program, including Medicaid?

Violation of Anti-Kickback

Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five years, or both.

Conviction will also lead to automatic exclusion from Federal health care programs, including Medicare and Medicaid.

What about discounts?

For [local government health care providers for extremely indigent patient populations], this [discounting] practice, while not protected by [the waiver of beneficiary deductible and coinsurance amounts] safe harbor regulation, would not likely violate the statute so long as the partial forgiveness of the copayment obligation was strictly a pragmatic financial decision and not an inducement to patients to purchase medical services.

Discounts that offer patients the option of reduced payment at time of service as a strategy for more successful bill collection

56 Fed. Reg. 35952, 35962-63 (July 29, 1991)

Routine Waiver of Co-Pays and Deductibles

U.S. ex rel. Abrahamsen v. Hudson Valley Hematology-Oncology Associates, R.L.L.P. (S.D.N.Y. 2016)

- $5.31 million settlement and CIA to resolve AKS and FCA violations
- Allegation: Routinely waived copayments for E/M services that did not meet (i) financial hardship exception or (ii) exhaustion of reasonable collection efforts
- Allegation: Overbilled Medicare by including amount of waived copayment in amount billed for service
- Noted copayment waivers in billing system by terms such as “write-off,” “down coding for Medicare,” and “professional courtesy”
- Takeaway: Waiver of coinsurance or deductible for documented financial need or after reasonable collection efforts have failed

https://www.justice.gov/usao-sdny/press-release/file/904411/download

Retention of Overpayments

U.S. ex rel. Hernandez-Gil v. Dental Dreams, LLC (D.N.M. 2018)

- Former employee alleged defendant dental practice retained overpayments in violation of FCA
- Management informed of billing practices but refused to allow investigation or audit
- “[I]t would cost too much money”
- District court denied summary judgment motion
- Reasonable jury could infer defendant “knew it received overpayments and took no steps to investigate, quantify, report, or return overpayments”
- Takeaway: Reasonably investigate potential overpayments, even when no overpayments specifically identified

Prompt Payment Discount

Factors:

Offered to all, timing of payment, and size of remaining balance

OIG Advisory Opinion No. 08-03

The Prompt Pay Discount would be offered in connection with both inpatient and outpatient services and would be offered to insured patients regardless of their financial status or their ability to pay. Patients would benefit from the Prompt Pay Discount in the following two circumstances: 1) when payments are made on a hospital bill prior to the discharge of the patient; or, 2) when payments are made after discharge, but within thirty (30) days of the patient's being informed of the discount offer. The size of the Prompt Pay Discount would depend on both the timing of the payment and the size of the remaining balance owed by the patient. The Prompt Pay Discount would be awarded according to the following schedule:

% of Bill Discounted on Payments Made Prior to Discharge

Balances $0 -- $999	=	10%
Balances ≥ $1,000	=	15%

% of Bill Discounted on Payments Made Post-Discharge But Within 30 days of Discount Offer

The Health System certified that it would:

NOT ADVERTISE THE DISCOUNT OPPORTUNITY. PATIENTS AND THEIR REPRESENTATIVES WOULD ONLY BE INFORMED OF THE PROMPT PAY DISCOUNT'S AVAILABILITY DURING THE COURSE OF THE ACTUAL BILLING PROCESS.

NOTIFY OTHER THIRD-PARTY PAYERS OF THE PROMPT PAYMENT POLICIES.

CERTIFY THAT ALL THE COSTS OF THE ARRANGEMENT WOULD BE BORNE BY THE HEALTH SYSTEM

CERTIFY THAT THE AMOUNT OF FEES DISCOUNTED TO PATIENTS UNDER THE PROPOSED ARRANGEMENT WOULD BEAR A **REASONABLE RELATIONSHIP TO THE AMOUNT OF AVOIDED COLLECTION COSTS.**

"WE BELIEVE THAT THESE FEATURES REDUCE THE LIKELIHOOD THAT THE PROPOSED ARRANGEMENT WOULD BE USED AS A MEANS TO DRAW ADDITIONAL PATIENT REFERRALS TO THE HEALTH SYSTEM AND IS CONSISTENT WITH THE CHARACTERIZATION OF THE PROPOSED ARRANGEMENT AS A PROMPT PAYMENT DISCOUNT IMPLEMENTED FOR THE PURPOSE OF MORE SUCCESSFUL BILL COLLECTION."

What is a "reasonable relationship to the amount of avoided collection costs"?

OIG Advisory Opinion No. 08-03

Anti-Trust Statement

Please be advised that any discussion which leads to an agreement as to price among competitors is a “per se” violation of the Sherman Act. Providers gathered in any setting must always exercise caution to avoid discussions or exchanges of information with their competitors on prices or pricing at meetings since such discussions or information exchanges may give rise to inferences of agreement.

Any agreement not to compete among business firms is also a “per se” violation of the antitrust laws. Thus, no discussion of division of territories or customers, or limitation on nature of business, should be held at any function. Joint refusals to deal (boycotts), including discussions of blacklists, are likewise unlawful “per se,” and no discussions related to these practices are permitted.

Discussion of fee or examples used are for instructional purposes only should not be considered as a recommendation for any provider or group of providers.

5 Most Dangerous Things

DUAL FEE SCHEDULE

IMPROPER TIME OF SERVICE DISCOUNTS

INDUCEMENT VIOLATIONS

ANTI-KICKBACK STATUTES

FALSE CLAIMS ACT

ChiroArmor

This has to stop.

Providing services at no charge to Medicare/Medicaid Patients

The Office of Inspector General

U.S. Department of Justice

D.C. from Iowa has agreed to pay $79,919 to resolve allegations DC **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 the doctor.** 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.

Triggered by Data!

Medicare Compliance

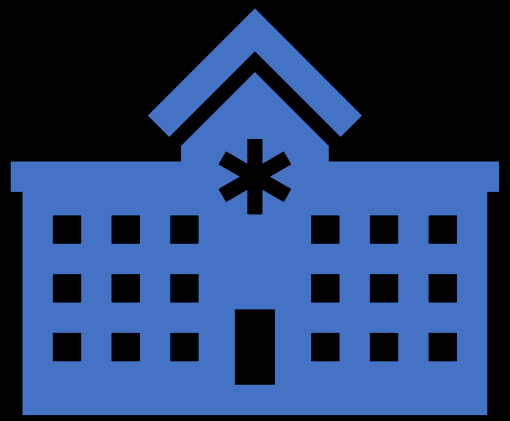
U.S. Department of Justice vs Dr. Friendly

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

Medicare Compliance



- 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.

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, groupon or other type of advertising system for new patients.
- Do not downcode or upcode services.

Opt-Out

- 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**.

- 40.4 - Definition of Physician/Practitioner (Rev. 62, Issued: 12-22-06, Effective: 11-13-06, Implementation: 04-02-07)

Enrollment Status Rule

42 CFR Parts 405, 410, 411, 414, 417, 422, 423, 424, 425, and 460 **requires providers** and suppliers in MA organization networks and other designated plans (hereafter including MA–PD plans, FDRs, PACE, Cost HMOs or CMPs, demonstration programs, pilot programs, locum tenens suppliers, and incident-to suppliers) **to be enrolled in Medicare in an approved status** (page 80445).

Mandatory Claims Submission Rule

ChiroArmor

- Applies to all physicians and suppliers
- You may not charge your patients for preparing or filing a Medicare claim.
- The requirement to submit does not mean you must accept assignment.
- M**andatory claim filing requirements is monitored by carriers**.
- Civil monetary penalty of up to $2,000 for each violation and/or Medicare program exclusion.
- Patients should be informed that a claim will be completed and filed on their behalf. If the patient is given a copy of the claim, the following statement (or one similar) should be documented in the claim: "Do not use this bill for claiming Medicare benefits. A claim will be submitted to Medicare on your behalf by this office."
- As a rule, **providers are not required to submit claims for non-covered services, unless requested by the patient.**

Medicare Advantage Plans

Whether a provider is under contract with a Medicare Advantage Plan or not, the provider is still **required to submit covered services to the primary insurance for a Medicare patient**. Out-of-network providers enrolled as Non-Participating (Non-PAR) with Medicare should **bill the Medicare Advantage Organization (MAO) directly** if the Medicare Advantage plan is the primary insurance for the patient.

Medicare Advantage Plans

While Medicare Advantage Organizations are generally required to reimburse non-contracted providers directly at no less than the Original Medicare rate, some MAO plans apply plan-specific non-assignment rules for out-of-network providers and may issue payment directly to the patient/beneficiary instead of the provider.

These payment practices vary by MAO and are not always apparent from general Medicare guidance. As a result, providers should verify payment methodology directly with the Medicare Advantage Organization prior to claim submission. When reimbursement is sent to the patient, privacy and authorization rules may limit the claims information that can be released to the provider unless the patient provides written authorization."

Medicare Advantage Plans

In summary, the provider should bill the Medicare Advantage plan directly as the primary payer and not bill Medicare Part B. The MAO is responsible for reimbursing the provider at least the Original Medicare rate, and the provider must accept this payment as full payment. If there are disputes, the provider should follow the MAO's internal dispute process first, then file a complaint directly with Medicare if not satisfied.

- Accessed on 1-16-2026 at https://www.govinfo.gov/content/pkg/FR-2016-11-15/pdf/2016-26668.pdf
- Accessed on 1-16-2026 at https://med.noridianmedicare.com/web/jeb/topics/claim-submission/mandatory-claims-submission#exceptions-to-mandatory-filing
- Accessed on 1-16-2026 at https://www.cms.gov/files/document/r12909cp.pdf
- Accessed on 1-16-2025 at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf

Payment Dispute Resolution Process for Non-contracted and Deemed Providers

Changes to Payment Dispute Process between Non-Contracted Providers, MAOs and Other Payers after January 31, 2014: From 2009 until January 31, 2014, CMS contracted the services of C2C Solutions, Inc., an independent entity, to adjudicate payment disputes between non-contracted providers, MAOs and other payers. As of January 31, 2014, providers should contact the MAO or other payer directly to dispute payments. This applies to all non-contracted provider types that perform services for beneficiaries enrolled in MAOs, including PFFS, PACE organizations, Section 1876 Cost Plans, and Section 1833 Health Care Prepayment Plans. If a provider has exhausted the plan's internal dispute process and still maintains it has not been reimbursed fairly, it may file a complaint through 1-800-Medicare in addition to taking other actions it deems appropriate. CMS does not offer advice to providers on their potential rights in a payment dispute.

Medicare Compliance

- The false belief that chiropractors can **opt out** of Medicare (**<u>you can't</u>**)
- 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.

The OIG Exclusion List

OIG Exclusion List

HHS-OIG's List of Excluded Individuals and Entities and General Services Administration's (GSA's) List of Parties **are debarred** from Federal Programs: such as Medicare, Medicaid, Maternal and Child Health Services Block Grant, Block Grants to States for Social Services, and State Children's Health Insurance programs.

ChiroArmor

http://oig.hhs.gov/fraud/exclusions.html

Very Important
OIG updates the exclusion list monthly…
Business Associates
New Hires
Reasonable Suspicion

Medicare Compliance

Case: chiropractor midwest office receives a letter from Medicare

Excluded from Medicare for 3 years and request for all $ for past 3 years.

What is the impact to my practice?

This payment prohibition applies to the **excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider for which the excluded person provides services, and anyone else**.

The exclusion applies regardless of who submits the claims and **applies to all administrative and management services furnished by the excluded person**.

EXCLUSION AUTHORITIES

Federal and State health care programs are prohibited from paying for items or services furnished, **either directly or indirectly**, by an excluded person or entity.

Recently expanded on January 2017, extends the authority to cover **all payment programs** for the provision of an items or services for which one request(s) or receive(s) payment from any Federal health care programs; and **indirect claims** are defined to include items and services that do not directly request or receive payment from Medicare, Medicaid, or other Federal health care programs, but that **provide items and services to providers, practitioners, or suppliers who request or receive payment from these programs** for such items or services

More than half of the states now include their own screening requirements along with the LEIE.

It’s important for a provider not to stop at referencing the LEIE alone.

EXCLUSION AUTHORITIES

Mandatory Exclusions

Social Security Act	42 USC §	Amendment
1128(a)(1)	1320a-7(a)(1)	Conviction of program-related crimes. Minimum Period: 5 years
1128(a)(2)	1320a-7(a)(2)	Conviction relating to patient abuse or neglect. Minimum Period: 5 years
1128(a)(3)	1320a-7(a)(3)	Felony conviction relating to health care fraud. Minimum Period: 5 years
1128(a)(4)	1320a-7(a)(4)	Felony conviction relating to controlled substance. Minimum Period: 5 years
1128(c)(3)(G)(i)	1320a-7(c)(3)(G)(i)	Conviction of second mandatory exclusion offense. Minimum Period: 10 years
1128(c)(3)(G)(ii)	1320a-7(c)(3)(G)(ii)	Conviction of third or more mandatory exclusion offenses. Permanent Exclusion

EXCLUSION AUTHORITIES

https://oig.hhs.gov/exclusions/authorities.asp

Permissive Exclusions

Social Security Act	42 USC §	Amendment
1128(b)(1)(A)	1320a-7(b)(1)(A)	Misdemeanor conviction relating to health care fraud. Baseline Period: 3 years
1128(b)(1)(B)	1320a-7(b)(1)(B)	Conviction relating to fraud in non-health care programs. Baseline Period: 3 years
1128(b)(2)	1320a-7(b)(2)	Conviction relating to obstruction of an investigation or audit. Baseline Period: 3 years
1128(b)(3)	1320a-7(b)(3)	Misdemeanor conviction relating to controlled substance. Baseline Period: 3 years
1128(b)(4)	1320a-7(b)(4)	License revocation, suspension, or surrender. Minimum Period: Period imposed by the state licensing authority.
1128(b)(5)	1320a-7(b)(5)	Exclusion or suspension under federal or state health care program. Minimum Period: No less than the period imposed by federal or state health care program.
1128(b)(6)	1320a-7(b)(6)	Claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of health care, or failure of an HMO to furnish medically necessary services. Minimum Period: 1 year
1128(b)(7)	1320a-7(b)(7)	Fraud, kickbacks, and other prohibited activities. Minimum Period: None
1128(b)(8)	1320a-7(b)(8)	Entities controlled by a sanctioned individual. Minimum Period: Same as length of individual's exclusion.
1128(b)(8)(A)	1320a-7(b)(8)(A)	Entities controlled by a family or household member of an excluded individual and where there has been a transfer of ownership/control. Minimum Period: Same as length of individual's exclusion.
1128(b)(9), (10), and (11)	1320a-7(b)(9), (10), and (11)	Failure to disclose required information, supply requested information on subcontractors and suppliers; or supply payment information. Minimum Period: None
1128(b)(12)	1320a-7(b)(12)	Failure to grant immediate access. Minimum Period: None
1128(b)(13)	1320a-7(b)(13)	Failure to take corrective action. Minimum Period: None
1128(b)(14)	1320a-7(b)(14)	Default on health education loan or scholarship obligations. Minimum Period: Until default or obligation has been resolved.
1128(b)(15)	1320a-7(b)(15)	Individuals controlling a sanctioned entity. Minimum Period: Same as length of entity's exclusion.
1128(b)(16)	1320a-7(b)(16)	Making false statement or misrepresentations of material fact. Minimum period: None.
1156	1320c-5	Failure to meet statutory obligations of practitioners and providers to provide medically necessary services meeting professionally recognized standards of health care (Quality Improvement Organization (QIO) findings). Minimum Period: 1 year

Professional Courtesy

Any compensation paid to a referrer or a family member of a referrer must be based on the fair market value of services provided and may not be related to the volume or value of any business referred to the practice.

General Prohibition on Paying, Offering, Soliciting, or Receiving Remuneration

…defines a professional courtesy as “the provision of free or discounted healthcare items or services offered to a physician, immediate family member, or office staff.”

Stark Law

Stark Law Professional Courtesy

The professional courtesy is offered to all physicians on the entity's bona fide medical staff or entity's local community or service area without regard to the volume or value of referrals or other business generated between the parties;

The healthcare items and services are of a type routinely provided by the entity;

The entity's professional courtesy policy is written and approved in advance by the board

What does the OIG say about Professional Courtesy?

Office of the Inspector General (OIG) oversees cases where professional courtesy may conflict with anti-kickback laws.

“In general, whether a professional courtesy arrangement runs afoul of the fraud and abuse laws is determined by two factors:”

1. How the recipients of the professional courtesy are selected; and
2. How the professional courtesy is extended.

- ✓If recipients are selected in a manner that directly or indirectly takes into account their ability to affect past or future referrals, the anti-kickback statute—which prohibits giving anything of value to generate Federal health care program business—may be implicated.
- ✓If the professional courtesy is extended through a waiver of copayment obligations (i.e., “insurance only” billing), other statutes may be implicated, including the prohibition of inducements to beneficiaries, section 1128A(a)(5) of the Act (codified at 42 U.S.C. 1320a–7a(a)(5)).
- ✓Claims submitted as a result of either practice may also implicate the civil False Claims Act.”

Medicare stipulates that a physician *cannot* bil l for services or ordered services for his/her **“immediate relatives”**

What about family members?

What is an “Immediate Relative”?

The following degrees of relationship are included within the definition of immediate relative:

- Husband and wife;
- Natural or adoptive parent, child, and sibling;
- Stepparent, stepchild, stepbrother, and stepsister;
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
- Grandparent and grandchild; and
- Spouse of grandparent and grandchild.

NOTE:

A step-relationship and an in-law relationship continue to exist even if the marriage upon which the relationship is based terminates through divorce or through the death of one of the parties.

For example, if a physician treats his step-father after the death of his natural mother or after the step-father and natural mother are divorced, or if he treats his father-in-law or mother-in-law after the death of his wife, the services are considered to have been furnished to an immediate relative and are excluded from coverage.

Professional Courtesy Scenarios

Selective Professional Courtesy

In this example, a urologist extends professional courtesy to seven hand-picked doctors in his geographical area. Five of these doctors could pass referrals to the urologist. The other two could not. This implicates the anti-kickback statute because the urologist displays a preference for granting PC in exchange for Federal health care referrals.

Waiver of copay with insurance billing

A physician visits a local clinic and receives service, but the clinic's physician waives her copay. The clinic's front office staff then submit a claim to the patient's insurance company. This violates the prohibition of inducements to beneficiaries, since the patient is now induced to return to the clinic for service (based on waiver of copay) and the clinic received compensation for the visit.

Generalized professional courtesy

A dermatologist extends Professional Courtesy to 25 physicians in his area, without limiting access. More than half of those physicians refer patients (or could refer them) to the dermatologist. Because he placed no restrictions or criteria on his PC and didn't cherry pick his beneficiaries, his use of PC is considered safe and legal.

Financial need

An E.R. doc has fallen on hard times. He visits his G.P. at a local clinic, and the G.P. waives his copay. The G.P. has never extended PC to anyone else. Even though the E.R. doc has referred business to the G.P. in the past, the G.P. is still most likely in the clear, since the E.R. doc has a clear financial need.

Guilt by Omission

An allergist extends professional courtesy to 20 other local physicians, waiving copays and not billing insurance. When a G.P. colleague stops referring patients to her, the allergist withdraws PC in that one instance. The allergist is now in jeopardy with the fraud and abuse laws, since she has displayed a selection preference for other physicians who provide referrals.

Inconsistent use

A cardiologist sometimes extends professional courtesy to his peers, but sometimes doesn't. He isn't trying to induce referrals or foster personal gain, but he doesn't have a clear policy in place and sometimes it slips his mind. In this case, he's putting himself at risk because a case could be made that his application of Professional Courtesy is selective.

Questionable use

An ENT doc provides professional courtesy to all other physicians within a 10-mile radius. An allergist 20 miles distant suddenly demonstrates the potential to refer a high volume of patients to the ENT. The ENT is in danger because she shows signs of biased selection of her Professional Courtesy beneficiaries based on referrals in this one case.

Proper use

In this professional courtesy example, a chiropractor routinely offers professional courtesy to a wide range of other physicians. When she waives a physician's copay, she doesn't submit claims to their insurance companies. When she takes x-rays, she does submit claims to cover her costs, but in these instances, she also charges a copay. She has created a written Professional Courtesy policy with her compliance officer's help and has shared this document with her front office staff.

This is proper use of Professional Courtesy.

Gifts:
General Prohibition on Paying, Offering, Soliciting, or Receiving Remuneration

The federal Anti-Kickback Statute ("AKS") prohibits soliciting, offering, giving, or receiving remuneration in exchange for referrals for items or services covered by federal healthcare programs (e.g., Medicare and Medicaid) unless the arrangement fits within a regulatory exception. (42 USC 1320a-7b(b)).

Stark does contain a limited exception that allows an entity to give unsolicited non-monetary gifts (not cash or cash equivalents) of up to approximately $300 per calendar year if the gift does not take into account the business generated by the physician and otherwise does not violate the AKS (i.e., not one purpose of the gift is to generate or reward referrals). (42 CFR 411.357(k)).

The $300 limit is adjusted annually for inflation.

For FY2026, the aggregate limit is $535.

Gifts to Referring Physicians

Gifts must be nonmonetary (e.g., meals, event tickets, not gift cards or cash)

Stark Non-Monetary Compensation Safe Harbor applies if:

- Items or services are not cash or cash equivalents.
- Aggregate value is less than $535 (as adjusted per CPI) per calendar year.
- Not determined in manner that takes into account volume or value of referrals or other business generated by referring physician.
- Not solicited by physician or physician's practice.
- Does not violate the AKS or other state or federal law.

(42 CFR 411.357(k))

Gifts to Patients What does the OIG say about this?

Unlike the AKS, the OIG has approved nominal gifts if they are not cash or cash equivalents, and they have a retail value of less than $15 individually or an aggregate value of $75 per year per patient. (OIG Bulletin, Offering Gifts and Inducements to Beneficiaries (8/02); 66 FR 24410-11). As with the AKS, the CMPL does not apply to private pay patients, although state kickback, rebate or fee splitting statutes may apply.

As a practical matter, providers are likely safe if they fit within the $15/$75 limits for gifts to patients.

Gifts from Vendors

The AKS may also apply to gifts offered by vendors: it prohibits providers from soliciting or receiving such gifts as a reward or in exchange for referring federal program business to the vendors. (See OIG Compliance Program Guidance for Pharmaceutical Manufacturers, 68 FR 23738). As with other gifts between referral sources, you should not accept gifts of more than **nominal value** if you have referred or may refer federal program business to the vendor.

In addition, such gifts may also trigger reporting requirements under the Sunshine Act regulations. (42 CFR part 403).

Conclusion

Well-intentioned gifts between referral sources (and patients, other providers) may have unintended consequences. Healthcare professionals should ensure that they and their staff comply with the rules cited along with additional relevant state laws.

Ask yourself these questions about giving or receiving gifts…

- **Is the recipient a referral source for items or services covered by govt programs?**
  - Referring providers?
  - Patients who are govt beneficiaries?

- **Why are you giving the gift?**
  - To thank them for past referrals or business?
  - To encourage future referrals or business?

- **Why are you giving the gift to this person and not others? Is it because:**
  - The recipient is a good source of business?
  - You hope to receive future business as a result of the gift?

Red Flags

- ✓ Gifts to or from sources who refer govt program business.
- ✓ Gifts to govt program beneficiaries.
- ✓ Gifts to physicians who refer designated health services payable by Medicare.
- ✓ Gifts based on referral patterns.
  - – Gifts are only given to those who refer business.
  - – Bigger gifts are given to those who refer more business.
- ✓ Gifts to patients who receive significant services.
- ✓ Gifts that are given shortly after significant services were provided.

Good Faith Estimates

What is a “good faith estimate”?

Good faith estimate means a **notification of expected charges for a scheduled or requested item or service**, including items or services that are **reasonably expected to be provided** in conjunction with such scheduled or requested item or service, provided by a convening provider, convening facility, co-provider, or co-facility.

Consists of expected items and services which will allow uninsured (or self-pay) individuals to have access to information about health care pricing before receiving care.

Provided orally AND either by paper or electronically at the patient’s preference.

45 CFR 149.610 requires issuance of good faith estimates for uninsured (or self-pay) individuals.

The law is intended to provide uninsured (or self-pay) individuals with clear and understandable information regarding the expected costs of items or services from health care providers.

No Surprises Act

45 CFR § 149.610 — Scope & Definitions

The regulation governing good faith estimates defines who must receive one:

“Uninsured (or self-pay) individual means:

(A) An individual who does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, **Federal health care program** (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan…

(B) An individual who has benefits for such item or service… but *does not seek to have a claim… submitted to such plan or coverage.”

Section 1128B(f) of the Social Security Act defines any plan or program funded directly, in whole or in part, by the United States Government (with some exceptions) as a federal health care program, and Medicare is considered one of the most significant programs covered.

Good Faith Estimates

When a Medicare Part B patient receives non-covered chiropractic services, the No Surprises Act does apply, and a Good Faith Estimate is required.

ABNs protect you when Medicare might deny manipulation.

GFEs protect the patient when Medicare never covers the service.

Who is defined as an Uninsured or "Self-Pay" individual?

Does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal Health Care Program (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code[7],[8];

or

Has benefits for such items/services under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a health benefits plan under chapter 89 of title 5, United States Code, but does not seek to have a claim submitted to their plan, issuer, or carrier for the item or service.

What procedures do I need to put into place in my practice to comply with this rule overall?

Summary:

1. Give notice.
2. Provide Good Faith Estimate.
3. Obtain consent.
4. Understand the dispute resolution process.

Notice Requirements

Drafting the specific good faith notice of expected charges for each qualified patient.

Display the notice on clinic website.

Display in two prominent locations – where scheduling and payment occur.

Practice Name
Location of Service: Practice Address

Provider Name
Provider NPI #
Provider TIN #

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call [INSERT PHONE NUMBER].

Make publicly available, post on a public website, and provide a one-page notice to individuals regarding:

(1) The requirements and prohibitions applicable to the provider or facility under sections 2799B–1 and 2799B–2 of the PHS Act and their implementing regulations;

(2) Any applicable state balance billing requirements; and

(3) How to contact appropriate state and federal agencies if the individual believes the provider or facility has violated the requirements described in the notice.

When do we provide the good faith estimate to the patient?

Timeframe
"Legislative Intent"

"Therefore, HHS is using its general rulemaking authority to establish in 45 CFR 149.610(b)(1)(iii) that the convening provider or facility must inform uninsured (or self-pay) individuals that good faith estimates of expected charges are available to uninsured (or self-pay) individuals **upon scheduling an item or service or upon request**."

Good Faith Estimate Procedure

1. Inquire about the individual's health insurance status or whether an individual is seeking to have a claim submitted to their health insurance coverage for the care they are seeking.
2. Make a determination if the patient has covered benefits or if the patient is uninsured or if the patient will be waiving their insurance submission and will be considered self-pay.
3. If Uninsured or Self-Pay, then provide a good faith estimate of expected charges for items and services, including items and services which would be reasonably expected to be provided together with the primary item or service, including items or services that may be provided by other providers and facilities.
    - (For example, if the patient makes an appointment as a new patient, provide oral notice of an estimate of charges expected for this first visit – which can be in a range of costs based on the provider's evaluation, ordering of x-rays, etc.)
4. Complete a Good Faith Estimate form and have it ready for the patient to sign when they arrive for their appointment.
5. Once a treatment plan has been established, provide the patient with a Good Faith Estimate of the total cost for the treatment.
6. Update the Good Faith Estimate if the treatment plan changes.

Good Faith Estimate Form

Practice Name
Location of Service: Practice Address

Provider Name
Provider NPI #
Provider TIN #

Good Faith Estimate for New Patient/New Episode
(Initial Visit Estimate)

Date: _____ **Patient Name:** _____ **Date of Birth:** _____

*Good faith estimates will be issued upon scheduling or upon request based upon the treatment plan

Diagnosis Codes	Description of Item or Service*	CPT Code	Quantity	Expected Charges
			Total Expected Charges from Provider:	
			Total Expected Charges from Co-Provider:	

I understand that:

- There may be additional items or services the convening provider or convening facility recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate.
- The information provided in the good faith estimate is only an estimate of items or services reasonably expected to be furnished at the time the good faith estimate is issued to the uninsured (or self-pay) individual and that actual items, services, or charges may differ from the good faith estimate.
- You have the right to initiate the patient-provider dispute resolution process if the actual billed charges are $400 more than the expected charges included in the good faith estimate and the dispute is initiated within 120 days after the date of the bill for the items or services. To start the process, you may contact us at the phone number or address listed above to let us know the billed charges are higher than the Good Faith Estimate. You can ask us to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services within 120 calendar days (about 4 months) of the date on the original bill and if the agency disagrees with you, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises.
- The good faith estimate is not a contract and does not require you to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

• Patient Please Review • Print & Sign Name •

I have discussed or been given the opportunity to discuss any questions or concerns with my provider and have had these answered to my satisfaction prior to my signing this Good Faith Estimate document. I have made my decision voluntarily and freely.

Patient's Name (Print)_____ Signature_____ Date_____

Patient Guardian/Representative (Print) _____ Signature_____ Date_____

Provider Signature_____ Date_____

Good Faith Estimate Scenarios

New Patients

New Episodes (Established Patients)

Maintenance Therapy

PRN Basis Care

Dispute Resolution Process

What would spark a dispute with a patient?

“Substantially in Excess”

If the patient receives a bill which is $400 or more above the good faith estimate provided to them at the beginning of care, then the patient is eligible to proceed into a dispute resolution process with the provider (if initiated within 120 days of receiving the bill).

Track your patient's Good Faith Estimate amount to avoid a potential dispute.

When aggravations or exacerbations occur during the course of the patient's treatment, updating the Good Faith Estimate may be required to avoid your original estimate to be considered substantially in excess.

Resources

- Overview:
  - https://www.cms.gov/nosurprises/Policies-and-Resources/Overview-of-rules-fact-sheets
- Requirements Related to Surprise Billing; Part I:
  - https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i
- Requirements Related to Surprise Billing; Part II:
  - https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii
- Other References:
  - CMS-9909-IFC: Requirements Related to Surprise Billing; Part I
  - CMS-9909-IFC Fact Sheet: What You Need to Know about the Biden-Harris Administration's Actions to Prevent Surprise Billing
  - Model Notice & Consent Templates
  - FAQ for CAA implementation, August 20, 2021
  - Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement NPRM
  - Air Ambulance NPRM – Fact Sheet
  - CMS-9908-IFC: Requirements Related to Surprise Billing; Part II
  - CMS-9908-IFC Fact Sheet: What You Need to Know about the Biden-Harris Administration's Actions to Prevent Surprise Billing (September 2021)

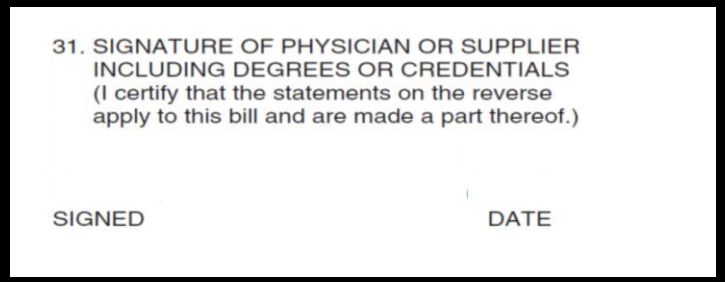
ChiroArmor

Coding Guidelines

Medicare Policy

What duty do Providers owe the Federal health care programs?

Claim Form Language: CMS 1500


31. SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse
apply to this bill and are made a part thereof.)

SIGNED DATE

Claim Form Language: CMS 1500

The answer is that all health care providers have a duty to reasonably ensure that the claims submitted to Medicare and other Federal health care programs are true and accurate.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

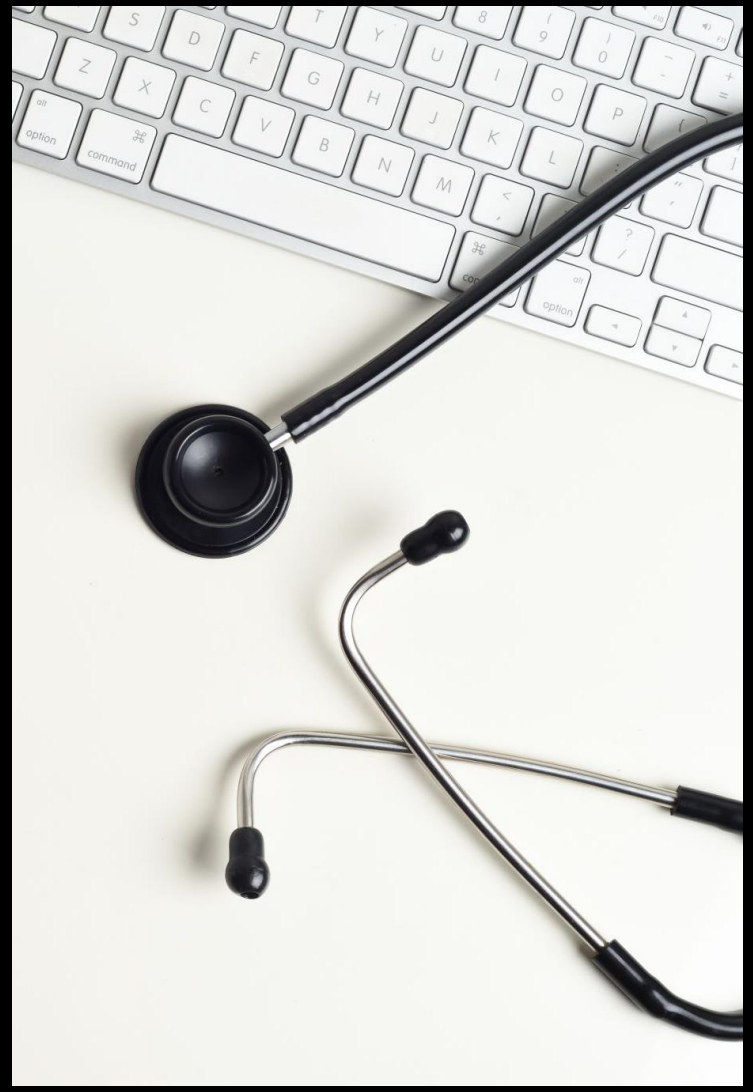
For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

Claim Form Language: CMS 1500



Medical Necessity

Medical necessity is defined as services that are **reasonable and necessary** for the diagnosis or treatment of an illness or injury or to **improve the functioning** of a malformed body member and are not excluded under another provision of the Medicare Program.

Claim Form Instruction Manual

http://nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2012_02-v4.pdf

The precise level of subluxation must be specified on the claim and must be listed as the primary diagnosis.

The neuromusculoskeletal condition necessitating the treatment must be listed as the secondary diagnosis.

Coding Guidelines

Coding Guidelines

All claims for chiropractic services must include the following information:

- Date of the initiation of the course of treatment.
- Symptom/condition/Secondary diagnosis code(s)
- Subluxation(s)/Primary diagnosis code(s)
- Date of Service
- Place of Service
- Procedure Code

Failure to report these items will result in claim denial or delay.

The date of the initial treatment or the date of the exacerbation of the existing condition must be entered in Item 14 of Form CMS-1500 or the electronic equivalent.

Specify the precise spinal location and level of subluxation giving rise to the diagnosis and symptoms.

Physician signature for progress notes and reports (handwritten, electronic). Initials if signed over a typed or printed name or accompanied by a signature log or attestation statement.

Recorded and Kept on File…

Non-Covered Services

Chiropractors are **not required** to bill non-covered services to Medicare.

Chiropractic offices **may want to submit charges to Medicare to obtain a denial** necessary for submitting to a secondary insurance carrier.

The following are examples of (not an all inclusive list) of services that, when performed by a Chiropractor, are excluded from Medicare coverage. - Laboratory tests - X-rays - Office Visits (history and physical) - Physiotherapy - Traction - Supplies - Injections - Drugs - Diagnostic studies including EKGs - Acupuncture - Orthopedic devices - Nutritional supplements and counseling.

Billed Services

Your patient has the option to determine if non-payable and/or non-covered services may be billed to Medicare by completing the ABN.

All covered services (payable or non-payable) provided to a Medicare patient must be billed to Medicare.

No other diagnostic or therapeutic service furnished by a chiropractor or under his or her order is covered.

Manual Manipulation (98940, 98941, 98942)

AT Modifier

The AT Modifier is ONLY used when HCPCS Codes 98940, 98941, 98942 is billed for active/corrective treatment.

The AT modifier **must not** be placed on the claim when maintenance therapy has been provided.

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.

Claims without the AT modifier will be considered as maintenance therapy and denied.

Modifier AT

Acute or Active Treatment

Instructions

This Chiropractic only modifier tells Medicare that this treatment should be covered as acute or active treatment.

Correct Use

- Chiropractic manual manipulation of spine service for acute therapy
  - Involves CPTs 98940, 98941 and 98942 only
- Corrective treatment supporting the manipulation
  - Not considered Maintenance therapy (see modifier GA)
  - Documentation MUST support acute/active/corrective treatment

Incorrect Use

- Do not bill modifier AT with denial modifiers (GA, GX, GY or GZ) on same line

Claim Coding Example

An established patient complains of upper back pain due to gardening.

Treatment Description	CPT/Modifier
Chiropractic Manipulative Treatment (CMT); spinal, three to four regions	98941 AT

MODIFIER AT

https://med.noridianmedicare.com/web/jeb/topics/modifiers/AT

MUST CODE TO THE HIGHEST LEVEL OF SPECIFICITY

QUESTION: IF YOU WERE AUDITED AND YOUR PATIENT WAS INTERVIEWED, WOULD THE EVIDENCE CONVICT YOU OF PERFORMING MANIPULATION?

“I don’t need to bill Medicare… I’ll just charge a 97140 (or whatever code Medicare doesn’t cover) and the patient can pay cash…”

If the provider uses the AT Modifier and believes a service is likely to be denied by Medicare as not being medically necessary, the beneficiary must sign an **Advance Beneficiary Notification (ABN) and the GA modifier** must be used.

Limitation of Liability Rules

These can be used by physicians, practitioners, or suppliers to indicate services that are expected to be denied because of lack of medical necessity or statutory exclusion, and those that do not meet the definition of any Medicare benefit.

GA, GP, GX, GY, and GZ Modifiers

GA Modifier

"Waiver of liability statement issued as required by payer policy" – Used to report when a mandatory ABN was issued to a beneficiary for a covered service that is not likely to be covered by Medicare due to medical necessity.

This modifier is frequently used by Chiropractors to indicate that spinal manipulation is being provided as maintenance care.

GY Modifier

"Notice of liability not issued, not required under payer policy" – Should be used on all services that are statutorily excluded or do not meet the definition of any Medicare benefit. Providers do not have to submit claims for noncovered services (e.g., massage, therapy, x-ray, etc.) unless the beneficiary requests claims are submitted, or if a denial is needed for secondary insurance claims processing.

Providers may voluntarily use an ABN form to advise beneficiaries of services that Medicare does not cover under any circumstances.

Refer to the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN) Matters article MM6563, Billing for Services Related to Voluntary Uses of Advance Beneficiary Notices of Noncoverage (ABNs)

Reporting with the GP Modifier

Provided an ABN when statutorily excluded services delivered under an outpatient physical therapy plan of care and used with GY modifier. Examples include: G0283-Electric Stimulation, 97035 Ultrasound, 97024 Diathermy, 97140 Manual Therapy, 97110 Therapeutic Exercises, 97112 Neuromuscular Re-Ed, 97530 Therapeutic Activities, etc.

GX Modifier

“Notice of liability issued, voluntary under payer policy” – Used to report when a voluntary ABN was issued for a service. The GX modifier would be appended in addition to the GY modifier.

A provider voluntarily gave the patient an ABN for a service that is not covered or expected to be denied, even if not legally required.

Use: Attach to a claim when you provide a courtesy ABN for a non-covered item (like a shower chair) to show the patient was informed. It's often used with the GY modifier on the same line to get an official denial for patient liability

GZ Modifier

"Item or Service Expected to Be Denied as Not Reasonable and Necessary"
– Used when a provider does not expect a service to be covered by Medicare, and does not have a valid ABN on file.

Beneficiaries are not liable for payment of services, when they were not notified prior to the services being rendered that the service would not be covered by Medicare due to medical necessity.

Medicare Policy Compliance

- PART I: Compliance Program Requirements
- PART II: Medicare Documentation Requirements
- PART III: Federal Health Care Regulations
- **PART IV: Enrollment and Participation**

PART IV
Enrollment and Participation

Medicare policy rules regarding provider enrollment and participation.

Medicare Benefit Policy Manual
Chapter 15 - Covered Medical and Other Health Services

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673

Medicare Provider Enrollment

Defined as institutional health care facilities, including hospitals, skilled nursing facilities, home health agencies, hospices and others (42 U.S.C. 1395x(u))

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications/

ACO participant in an ACO that failed to satisfactorily report on behalf of its EPs and would not be available to EPs and group practices that failed to report for purposes of PQRS outside the Shared Savings Program. We are finalizing our proposal that these affected EPs may utilize the secondary reporting period either as an individual EP or as a group practice using one of the registry, QCDR, direct EHR product, or EHR data submission vendor reporting options. We are also finalizing our proposal that such EPs do not need to register for the PQRS GPRO for the 2017 PQRS payment adjustment. In addition, we are finalizing at § 414.90(j)(4)(v) our proposal that sections § 414.90(j)(8)(ii), (iii), and (iv) would apply to affected EPs reporting as individuals using this secondary reporting period for the 2017 PQRS payment adjustment. Further, we are finalizing at § 414.90(j)(7)(viii) our proposal that sections § 414.90(j)(9)(ii), (iii), and (iv) would apply to affected EPs reporting as group practices using this secondary reporting period for the 2017 PQRS payment adjustment. We are finalizing at § 414.90(k)(4)(ii) our proposal that § 414.90(k)(5) would apply to affected EPs reporting as individuals or group practices using this secondary reporting period for the 2017 PQRS payment adjustment. We are finalizing our proposal that the secondary reporting period for the 2017 PQRS payment adjustment would coincide with the reporting period for the 2018 PQRS payment adjustment (that is, January 1, 2016 through December 31, 2016). In addition, we are finalizing a policy under which we will assess the individual EP or group practice's 2016 data using the applicable satisfactory reporting requirements for the 2018 PQRS payment adjustment (including, but not limited to, the applicable PQRS measure set). If an affected individual EP or group practice decides to use the secondary reporting period for the 2017 PQRS payment adjustment, the EP or group practice should expect to receive a PQRS payment adjustment for services furnished in 2017 until we are able to determine that the EP or group practice satisfactorily reported for purposes of the 2017 PQRS payment adjustment. Further, we are finalizing our proposal that the informal review submission periods for these EPs or group practices would occur during the 60 days following the release of the PQRS feedback reports for the 2018 PQRS payment adjustment.

I. Medicare Advantage Provider Enrollment

1. Background

a. General Overview

The Medicare program is the primary payer of health care for approximately 54 million beneficiaries and enrollees. Section 1802(a) of the Act permits beneficiaries to obtain health services from any individual or organization qualified to participate in the Medicare program. Providers and suppliers furnishing items or services must comply with all applicable Medicare requirements stipulated in the Act and codified in the regulations. These requirements are meant to promote quality care while protecting the integrity of the program. As a major component of our fraud prevention activities, we have increased our efforts to prevent unqualified individuals or organizations from enrolling in Medicare.

The term "provider of services" is defined in section 1861(u) of the Act as a hospital, a critical access hospital (CAH), a skilled nursing facility (SNF), a comprehensive outpatient rehabilitation facility (CORF), a home health agency (HHA), or a hospice. The term "supplier" is defined in section 1861(d) of the Act as, unless context otherwise requires, a physician or other practitioner, facility or other entity (other than a provider of services) that furnishes items or services under title XVIII of the Act. Other supplier categories may include, for example, physicians, nurse practitioners, and physical therapists.

Providers and suppliers that fit into these statutorily defined categories may enroll in Medicare if they meet the proper screening and enrollment requirements. This final rule will require providers and suppliers in MA organization networks and other designated plans (hereafter including MA–PD plans, FDRs, PACE, Cost HMOs or CMPs, demonstration programs, pilot programs, locum tenens suppliers, and incident-to suppliers) to be enrolled in Medicare in an approved status. We generally refer to an "approved status" as a status whereby a provider or supplier is enrolled in, and is not revoked from, the Medicare program. For example, a provider or supplier that has submitted an application, but has not completed the enrollment process with their respective Medicare Administrative Contractor (MAC), is not enrolled in an approved status. The submission of an enrollment application does not deem a provider or supplier enrolled in an approved status. A provider or supplier that is currently revoked from Medicare is not in an approved status. Out-of network or non-contract providers and suppliers are not required to enroll in Medicare to meet the requirements of this final rule with respect to furnishing items and services to MA enrollees.

b. Background

To receive payment for a furnished Medicare Part A or Part B service or item, or to order, certify, or prescribe certain Medicare services, items, and drugs, a provider or supplier must enroll in Medicare. The enrollment process requires the provider or supplier to complete, sign, and submit to its assigned Medicare contractor the appropriate Form CMS–855 enrollment application. The CMS–855 application form captures information about the provider or supplier that is needed for CMS or its contractors to screen the provider or supplier, verify the information provided, and determine whether the provider or supplier meets all Medicare requirements. This screening prior to enrollment helps to ensure that unqualified individuals and entities do not bill Medicare and that the Medicare Trust Funds are accordingly protected. Data collected and verified during the enrollment process generally includes, but is not limited to: (1) Basic identifying information (for example, legal business name, tax identification number); (2) state licensure information; (3) practice locations; and (4) information regarding ownership and management control.

We strive to further strengthen the provider and supplier enrollment process to prevent problematic providers and suppliers from entering the Medicare program. This includes, but is not limited to, enhancing our program integrity monitoring systems and revising our provider and supplier enrollment regulations in 42 CFR 424, subpart P, and elsewhere, as needed. With authority granted by the Act, including provisions in the Affordable Care Act, we have revised our provider and supplier enrollment regulations by issuing the following:

- In the February 2, 2011 **Federal Register** (76 FR 5861), we published a final rule with comment period titled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers." This final rule with comment period implemented major Affordable Care Act provisions, including the following:

ChiroArmor

What about Medicare Advantage Plans?

2016 Rule Change requires providers to enroll in Medicare

Medicare Provider Enrollment, Chain, and Ownership System (PECOS)

PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.

https://pecos.cms.hhs.gov/pecos/login.do#headingLv1

Provider Agreements

Providers enter into provider agreements with Medicare, agreeing to abide by the applicable Conditions of Participation (CoPs) and laws

Par vs. Non-Par

What is the difference and how do I comply?

Par vs. Non-Par

Medicare sets limits on what the patient can be charged by both par and non-par providers. The "limiting charge" for the par provider will be slightly higher than the "limiting charge" for the non-par provider.

Active Treatment

- Medicare will directly reimburse the par provider for the payable covered services provided. The patient is required to pay for the non-covered services.
- The patient is required to pay the non-par provider for the all services provided.

Maintenance Therapy

- The patient is responsible for all services provided up to the provider's normal fee. The limiting fee does not apply to non-payable covered services.

Accepting Assignment

Medicare will reimburse the provider at 80% of the covered service.

Effective Date of Medicare Billing Privileges

The effective date for Medicare billing privileges is the later of:

- ✓The date of filing of a Medicare enrollment application that was subsequently approved by CMS; or
- ✓The date the supplier first began furnishing services at a new practice location

Always check with your MAC

Enrollment Revalidations

Section 6401(a) requires all existing providers and suppliers to revalidate their enrollment information under new enrollment screening criteria.

Normally required to revalidate Medicare enrollment every 5 years (every 3 years for DMEPOS)

CMS reserves the right to perform off-cycle revalidations as deemed necessary

CMS posts a list of all currently enrolled providers and their revalidation due date (except DMEPOS suppliers) (Data.CMS.gov/revalidation)

Revalidations are due on the last day of the month

Due dates are updated every 60 days at the beginning of the month

Due dates are listed up to 6 months in advance

Due dates not yet assigned will be listed as “TBD” (more than 6 months away)

MACs will send a revalidation notice within 2-3 months prior to revalidation due date

Notices sent via either email or postal mail

Required as condition of participating in Medicare to provide timely updates to any changes in information encompassed in your Form CMS-855 application.

Need to design a tracking mechanism of what was reported, and what/when that information changes.

Need to understand timelines.

Reporting Changes

Within 30 Days of the Effective Date of Change

- Change of ownership (CHOW)
- Final adverse legal actions (e.g., sanctions)
- Change in main practice location (including adding or deleting locations)
- Changes in authorized or delegated officials
- Changes to the entire governing body/board of directors

Within 90 Days of the Effective Date of Change

- Changes in managing employees
- Changes in administrator or medical director (for hospices)
- All other changes not specified in the 30-day list

Note: Failing to respond to an additional documentation request (ADR) from your MAC within 30 days can also lead to deactivation.

When Enrollment Goes Wrong

Adverse Enrollment Actions

Rejections (42 CFR 424.525)

CMS may reject a provider's or supplier's application if the provider or supplier fails to furnish complete information on the enrollment application within 30 calendar days from the date the contractor's request for missing information

CMS, at its discretion, may choose to extend the 30 day period if it determines that the provider or supplier is actively working with CMS to resolve any outstanding issues

Rejections
Common Mistakes

- Certification statement unsigned/undated
- Certification statement signed 120 days prior to the date on which the contractor received the application
- Failure to complete all required section of the application
- Failure to submit all supporting documentation
- Wrong application was submitted (e.g., Form CMS-855B was submitted for Part A enrollment)

Rejections

Enrollment applications rejected by CMS will require the provider to resubmit the application as a new application.

Result: The effective date will be the date in which the resubmitted application was filed because it was the resubmitted application “that was subsequently approved by CMS” instead of the initial application.

Enrollment applications that are rejected are not afforded appeal rights.

Deactivations (42 CFR 424.540(a), (c))

Reasons for Deactivation

- Failure to submit any Medicare claims for 12 consecutive calendar month: Effective date of deactivation = last day of 12-month period
- Failure to report a change of ownership or control within 30 days: Effective date of deactivation = expiration of 30-day period
- Failure to report a change of information within 90 days of when the change occurred (e.g., change in practice location, managing employee, billing services, etc.): Effective date of deactivation = expiration of the 90-day period
- Failure to respond to a revalidation request between 60-75 days after the revalidation due date: Effective date of deactivation = date CMS's deactivation action is taken (but after 60-75 day period)

Deactivations

Deactivation of Medicare billing privileges stops payments but does not terminate a provider's underlying participation agreement or conditions of participation, meaning they're still technically enrolled but can't bill Medicare until they fix the issue, which often involves submitting updated information or revalidating to be reinstated

Reactivations
(42 CFR 424.540(b))

Deactivations for failure to report a change of information, ownership, or control (e.g., practice location)

- Reactivation application is treated as an initial enrollment application
- New PTAN with new effective date
- Effective date = date provider submitted reactivation application (that was subsequently approved)
- Result: Provider is not entitled to retrospective billing for services rendered between the deactivation date and new effective date

- Required to submit a new full application
- The provider/supplier will maintain their original PTAN with a gap in coverage (between the deactivation and reactivation of billing privileges)
- No payments will be made for the period of deactivation

Deactivations for failure to respond to a revalidation request

Denials
(42 CFR 424.530)

Common Denial Reasons

- Not in compliance with enrollment requirements
- Excluded from any federal health care program
- Felony convictions
- False or misleading enrollment information
- On-site review
- Medicare debt
- Payment suspension

If the denial was not appealed, the date the provider's appeal rights have lapsed (i.e., 60 days following date of denial notice)

If appealed, provider has received notification that the determination was upheld

May not submit a new enrollment application until either of the following has occurred

Revocations (42 CFR 424.535)

Common Revocation Reasons

- Noncompliance with enrollment requirements
- Exclusion from any federal health care program
- Felony convictions
- On-site review
- Failure to report
- Abuse of billing privileges
- Medicaid termination
- Failure to document or provide CMS access to documentation
- Suspension/revocation of DEA Certificate of Registration
- Improper prescribing practices

Abuse of billing privileges

42 CFR 424.535(a)(8)

Type 1: Provider submits a claim or claims for services that could not have been furnished to a specific individual on the date of service (e.g., where the beneficiary is deceased or the directing physician or beneficiary is not in the state or county when services were furnished)

Type 2: CMS determines that the provider has a pattern or practice of submitting claims that fail to meet Medicare requirements

Abuse of Billing Privileges (42 C.F.R. § 424.535(a)(8)(ii))

CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement if CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements.

Interplay Between Revocations, Audits, and FCA Liability

Interplay Between Revocations, Audits, and FCA Liability

60-Day Overpayment Final Rule

Felony Convictions
42 CFR 424.535(a)(3)

Failure to Report
42 CFR 424.535(a)(9)

Provider failed to report (within 30 days):

Any adverse legal action
A change in practice location

Revocations
(42 CFR 424.535(g))

- When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS not to be operational, the revocation is effective with the date of exclusion or debarment, felony conviction, license suspension or revocation or the date that CMS determined that the provider or supplier was no longer operational.

- Otherwise, revocation becomes effective 30 days after CMS mails the notice of its determination to the provider or supplier.

What Can you do When Enrollment Goes Wrong?

- **Return** – Start over. Considered a "non- application"
- **Rejection** – Fix the deficient sections within 30 days from the date the "Development Letter" is mailed by MAC (but be mindful of CHOW/CHOI timelines)
- **Deactivation** – File to reactivate, no appeal rights.
- **Denial** – Corrective Action Plan, Request for Reconsideration, Appeal
- **Revocation** – Appeal, appeal, appeal…

Appeal Strategies

Appeal Options

Standard Process:

- Corrective Action Plan ("CAP")
- Request Reconsideration
- Appeal to Administrative Law Judge
- DAB Review
- District Court Review

Outside the Box:

- Contact CMS (RO or Central Office)
  Settlement discussions
- Contact the MAC (Hearing Officer)
- Contact Congressional Representative

Review by the Medicare Appeals Council

https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/AppealsCouncilReview

Corrective Action Plan (CAP)

Reconsideration Appeals

42 CFR § 498.5(l)(1)

– Any prospective provider, an existing provider, prospective supplier or existing supplier dissatisfied with an initial determination or revised initial determination related to the denial or revocation of Medicare billing privileges may request reconsideration in accordance with §498.22(a).

Appeal deadline = 60 days from receipt of the notice of revocation

Content of the request

– Reconsideration request must state the issues, or the findings of fact with which the affected party disagrees, and the reasons for disagreement.

Reconsideration decision must be issued within 90 days of the date of the appeal request. Medicare Program Integrity Manual, chapter 15, section 15.25.1.2.D.

Reconsideration Appeals
Key Considerations

ChiroArmor

Open communications with CMS and/or its contractors

Request opportunity to discuss findings via telephone conference

CMS (rather than its contractors) will make all determinations pertaining to revocations for abuse of billing privileges

Timing issues

Revocation becomes effective 30 days after the date of revocation notice

Exception: Revocations based on adverse actions (e.g., felony conviction, license suspension, federal exclusion) will be effective the date of the adverse action

Exception: Revocation based on practice location determined not to be operational by CMS will be effective the date on which CMS made such a determination (e.g., date of on-site visit)

Provider likely to be revoked while reconsideration appeal is pending review

Reconsideration Appeals
Timing issues

Revocation becomes effective 30 days after the date of revocation notice

Exception: Revocations based on adverse actions (e.g., felony conviction, license suspension, federal exclusion) will be effective the date of the adverse action

Exception: Revocation based on practice location determined not to be operational by CMS will be effective the date on which CMS made such a determination (e.g., date of on-site visit)

Provider likely to be revoked while reconsideration appeal is pending review

Reconsideration Appeals
Early presentation of evidence

"After a hearing is requested but before it is held, the ALJ will examine any new documentary evidence submitted to the ALJ by a provider or supplier to determine whether the provider or supplier has good cause for submitting the evidence for the first time at the ALJ level."
42 CFR § 498.58(e)

Reconsideration Appeals
Supplement the reconsideration request, if necessary

"Consistent with 42 CFR §498.24(a), the provider, the supplier, or the Medicare contractor may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request at any time prior to the [Hearing Officer's] decision." MPIM 15.25.1.2.D

ALJ Appeals
Recent Departmental Appeals Board (DAB) decisions

Cornelius M. Donohue, DPM, DAB No. 2888 (August 14, 2018)

In 2016, CMS revoked a podiatrist's Medicare billing privileges based on his 2006 felony conviction for obstruction of a Medicare audit. The podiatrist disclosed the conviction on his application to revalidate his Medicare enrollment, which was approved in 2011.

DAB upheld ALJ's decision that CMS lawfully revoked the podiatrist's Medicare billing privileges effective October 26, 2006.

Donald W. Hayes, D.P.M., DAB No. 2862 (March 30, 2018)

A podiatrist submitted at least 16 claims for Medicare payment for services rendered to beneficiaries who were deceased on the purported date of service. He did not intend to defraud the Medicare program and attributed the billing of claims to "typographical errors, mishandling, and adverse activity by billing personnel under [his] employ."

DAB upheld ALJ's decision that CMS lawfully revoked the podiatrist's Medicare billing privileges under 42 CFR § 424.535(a)(8) for abuse of billing privileges.

ALJ Appeals

- ALJ request must be submitted within 60 days from receipt of the reconsideration decision
- ALJ must issue a decision, dismissal order, or remand no later than the 180-day period from the date the ALJ appeal request was filed
- For revocation appeals, ALJs have consistently recognized that CMS's decision to revoke providers is an act of discretion on the part of CMS

ChiroArmor

Re-enrollment bar Overpayments

Collateral Consequences

Re-enrollment bar

- If a provider or supplier has its billing privileges revoked, the provider or supplier is barred from participating in the Medicare program from the date of the revocation until the end of the re- enrollment bar. 42 CFR 424.535(c)
- Re-enrollment bar period established by CMS will depend on the severity of the basis for revocation
  - Minimum re-enrollment bar = 1 year
  - Maximum re-enrollment bar = 3 years
- Length of re-enrollment bar issued by CMS cannot be challenged at ALJ hearing

Overpayments

- A physician, nonphysician practitioner, or physician/nonphysician practitioner organization that fails to report a final adverse action or change in practice location will be assessed an overpayment back to the date of the final adverse action or change in practice location. 42 CFR 424.565.
- No payment may be made for otherwise Medicare covered items or services furnished to a Medicare beneficiary by a revoked provider or supplier. 42 CFR 424.555.
  - ✓The beneficiary has no financial responsibility for any expenses, and the provider must timely refund to the beneficiary any amounts collected for those items/services.
  - ✓If any otherwise covered Medicare item/service is furnished by a revoked provider or supplier, any expense incurred for such item/service shall be the responsibility of the provider or supplier.
    - Provider or supplier may be criminally liable for pursuing payments from the beneficiary.

Collateral Consequences

- Revocation of related Medicare enrollments
- Medicaid termination
- Managed care contracts
- Commercial payor contracts
- Staff privileges for physicians
- Licensing issues

New Affiliation Rules

Effective as of November 4, 2019

New Rule: 52 C.F.R. § 424.519- “Disclosures of affiliations”

New rule authorizes CMS to deny or revoke enrollment based on disclosures of certain affiliations that CMS determines poses undue risk of fraud, waste, or abuse.

New Rule on Affiliates

- Purpose: Identify individuals that pose a risk to the program based on their previous relationships and sanctioned entities.
- Initially rule will apply to enrolling or revalidating providers/supplies selected by CMS.

Affiliation Defined

- 5% or greater direct or indirect ownership interest that an individual or entity has in another organization;
- A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization;
- An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to- day operations of another organization, either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W-2 employee or the organization;
- An interest in which an individual is acting as an officer or director of a corporation; or
- Any reassignment relationship under [42 § C.F.R. 424.80].

Look back period = 5 years

Disclosable Events

Any affiliation with an entity meeting the criteria below must be disclosed during enrollment and reverification.

Disclosable meaning:

- ✓Currently has uncollected debts to Medicare, Medicaid or CHIP
- ✓Has been or is subject to a payment suspension under a Fed Health care program
- ✓Has been or is excluded from Medicare, Medicaid or CHIP
- ✓Has had its Medicare, Medicaid, or CHIP billing privileges denied, revoked, or terminated.

Disclosable Events

- Timing of disclosable events is irrelevant.

- Any affiliation with a provider or supplier who had a payment suspension, exclusion or denial, revocation or termination of billing privileges- must be disclosed!

Reasonableness Standard

- CMS will use a “reasonableness” standard to determine enrollment denials or revocations.
- Definition: CMS requires “information to be reported only if the disclosing provider or supplier knew or should reasonably have known of said data.”
- Case by Case basis

Factors to Determine Fraud, Waste, or Abuse

1. Length and period of the affiliation.
2. Nature and extent of the affiliation.
3. Type of disclosable event and when it occurred.

The more recent and longer an affiliation, the more serious the disclosable event.

CMS New Authority

- Revoke a physician's or eligible professional's Medicare enrollment if he or she has a pattern or practice of ordering, certifying, referring, or prescribing Medicare Part A or B services, items, or drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements.
- Increase the maximum reenrollment bar from 3 to 10 years, with exceptions as stated in this rule.
- Prohibit a provider or supplier from enrolling in the Medicare program for up to 3 years if its enrollment application is denied because the provider or supplier submitted false or misleading information on or with (or omitted information from) its application in order to gain enrollment in the Medicare program.
- Revoke a provider's or supplier's Medicare enrollment if the provider or supplier has an existing debt that CMS refers to the United States Department of Treasury.

Goals for the New Rule

- CMS estimates an annual cost to providers and suppliers of $937,500 in each of the first 3 years of this rule.
- CMS estimates its new revocation authorities will lead to approximately 2,600 new revocations per year.
- CMS indicates these provisions will help make certain that entities and individuals who pose risks to the Medicare and Medicaid programs and CHIP are removed from and kept out of these programs;
- CMS also indicates this final rule will assist in preventing providers and suppliers from circumventing Medicare requirements through name and identity changes, as well as through elaborate, inter- provider relationships.

Questions or Comments?

Thank you!!