



COMPLIANCE
RE-IMAGINED

Medicare Compliance

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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 Compliance

Part I

Compliance Program and Federal Health Care Regulations



Compliance Program Requirements

OIG Requirements for Health Care Entities



Lesson 1 — Why Compliance Exists

Oversight grew from claims, records, and the need to prevent improper payment.



The pattern is consistent: questionable claims lead to record review — and the record tells the story.

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 Reference 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. 20550.

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; 8:40 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...



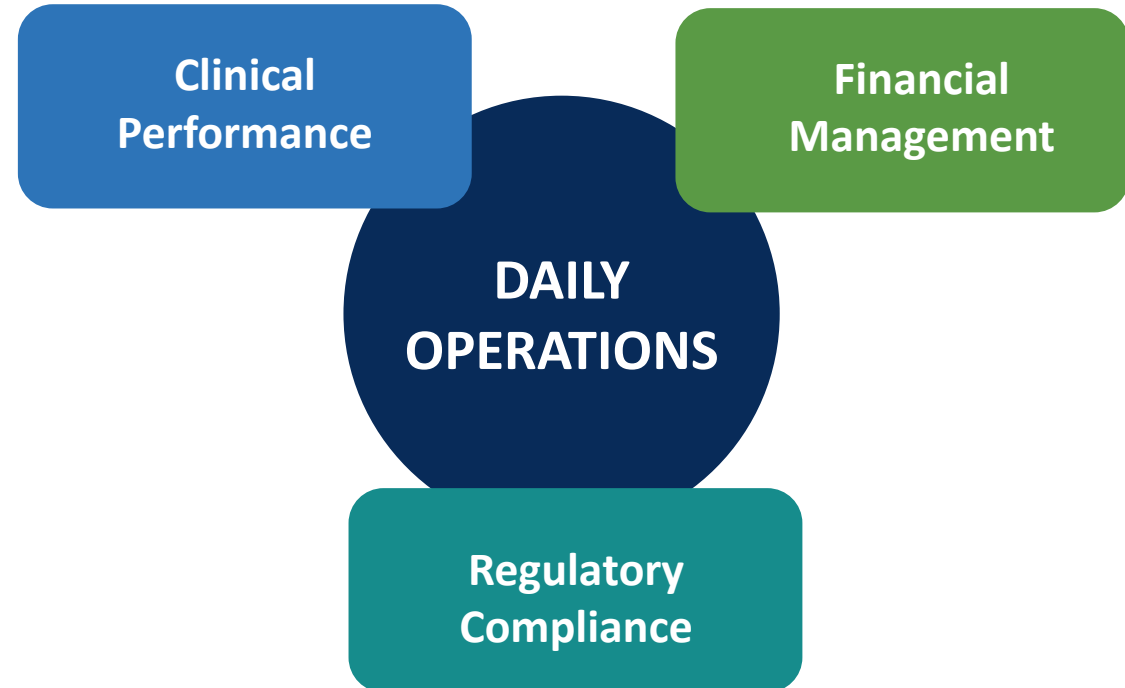
Goal

Let's Re-Imagine
Compliance



Make Compliance Operational

Compliance belongs inside the practice — not beside it.



Bake the rules into the workflow.

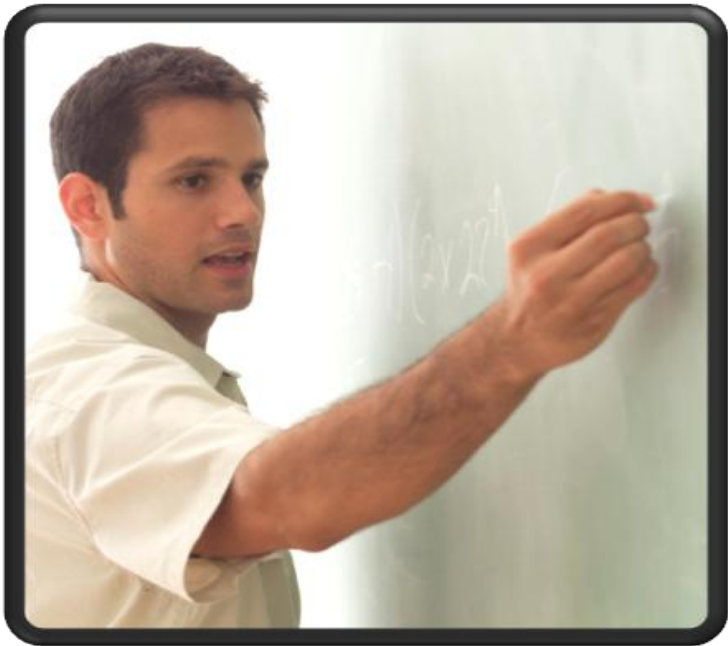


What is a compliance program?

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**
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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, Federal
Healthcare Laws, Medicare/Medicaid,
Coding, Billing, & Documentation...**



- 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; Obligorating 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

Employment Policy Components



Compliance Policy Components

I. Compliance Program Governance

- Introduction and Purpose
- Related Compliance Policy Manuals
- Duty to Report
- Open Lines of Communication
- Compliance Officer
- Standards of Conduct
- Policy Administration and Maintenance

II. Federal Healthcare Program Compliance

- Medicare
- Federal Health Care Regulations
- Medicare's Quality Payment Program

III. Documentation, Medical Necessity & Clinical Record Integrity

- Medical Necessity Determination
- Informed Consent
- Informed Refusal
- Clinical Records
- AI-Assisted Documentation & Patient Privacy Policy

IV. Coding, Billing & Payment Integrity

- Financial Policy
- Professional Courtesy
- Gifts Policy
- Coding and Billing
- Evaluation and Management (E/M) Coding
- Modifier Coding & Compliance
- Remote Therapeutic Monitoring (RTM) Coding & Compliance
- NPI and Billing Policy
- Locum Tenens and Reciprocal Billing Policy
- Credit Account Repayment

V. Patient Rights, Communication & Clinical Relationships

- Transportation Policy
- Service Animals
- Federal Requirements for Medical Interpreters
- Professional Boundaries
- Termination of a Patient Relationship
- Care Transitions
- Unexpected Provider Departure
- Practice Closure, Ownership Transfer & Office Relocation
- Patient Safety & Clinical Reliability
- Patient Complaint and Grievance

VI. Workforce & Professional Practice Controls

- New Service & Clinical Innovation Risk Control
- Telehealth & Remote Care Compliance
- Advertising / Marketing Compliance
- Patient Testimonials & Marketing Authorization
- Preceptorship / Student Interns

VII. Monitoring & Auditing

- Monitoring and Auditing
- Documentation Audit, Medical Necessity & Procedure Compliance

VIII. Compliance Oversight & Quarterly Review

- Quarterly Business Reviews

IX. Training & Education

- Training and Education

X. Investigations, Corrective Action & Enforcement

- Responding to Detected Offenses & Corrective and Preventive Action (CAPA)
- Internal and External Investigations
- Exit Interview

XI. Compliance Program Acknowledgement

- Acknowledgement of Compliance Program Requirements

XII. Addenda & Glossary

- Addendum
- Glossary of Terms



HIPAA POLICY



HIPAA Privacy Rule

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



HIPAA Security Rule Requirements

Safeguards

Administrative
Physical
Technical



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



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



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.



DEPARTMENT OF HEALTH AND
HUMAN SERVICES
Office of the Secretary
45 CFR Parts 160 and 164
RIN 0945-AA22

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>



OSHA POLICY



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?**



**There are 87 Risk Control Measures that
should be monitored and audited
throughout the year.**

Each year.



Timely Policy Updates

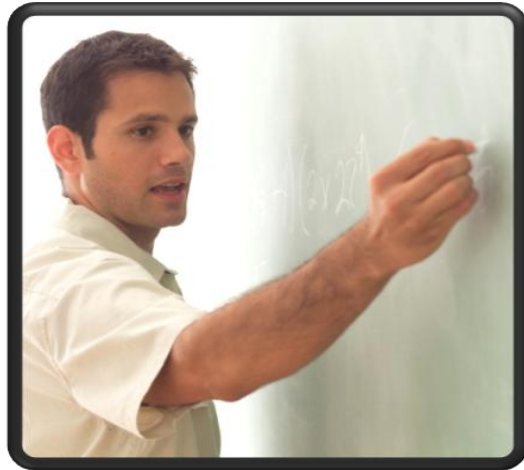


How do you cover oversight of compliance to documentation standards in your practice?

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

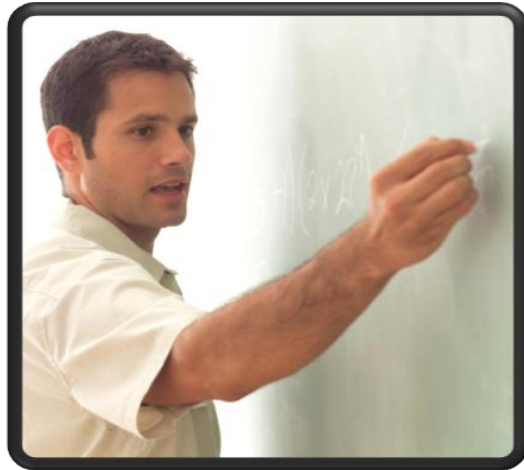


Conducting Appropriate Training and Education

Who?
What?
When?
How often?



Office of Inspector General (OIG)



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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)

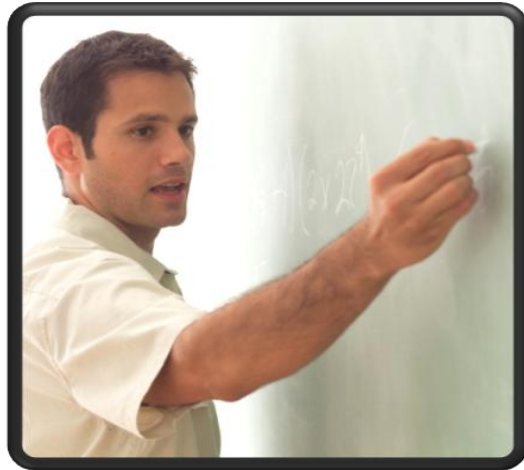
Responding Appropriately to Detected
Violations

What are your warning indicators?

How are you fixing the problem?



Office of Inspector General (OIG)



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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

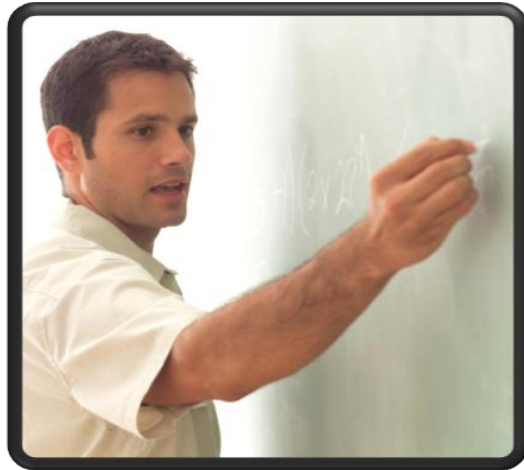


Standards of Conduct

- 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)



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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, Amount: _____

If Yes: Check Number: _____ Date: _____

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) 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...”**

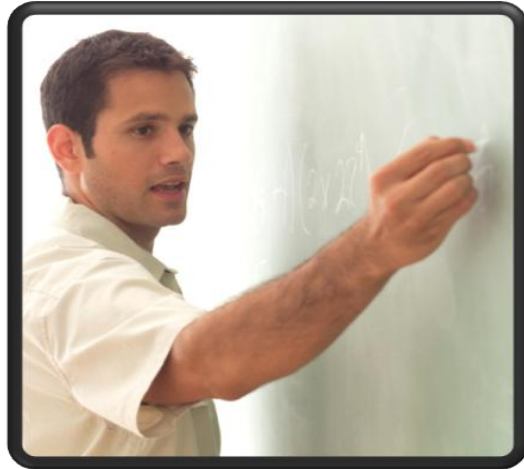


Zero Tolerance for Fraud Policy

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

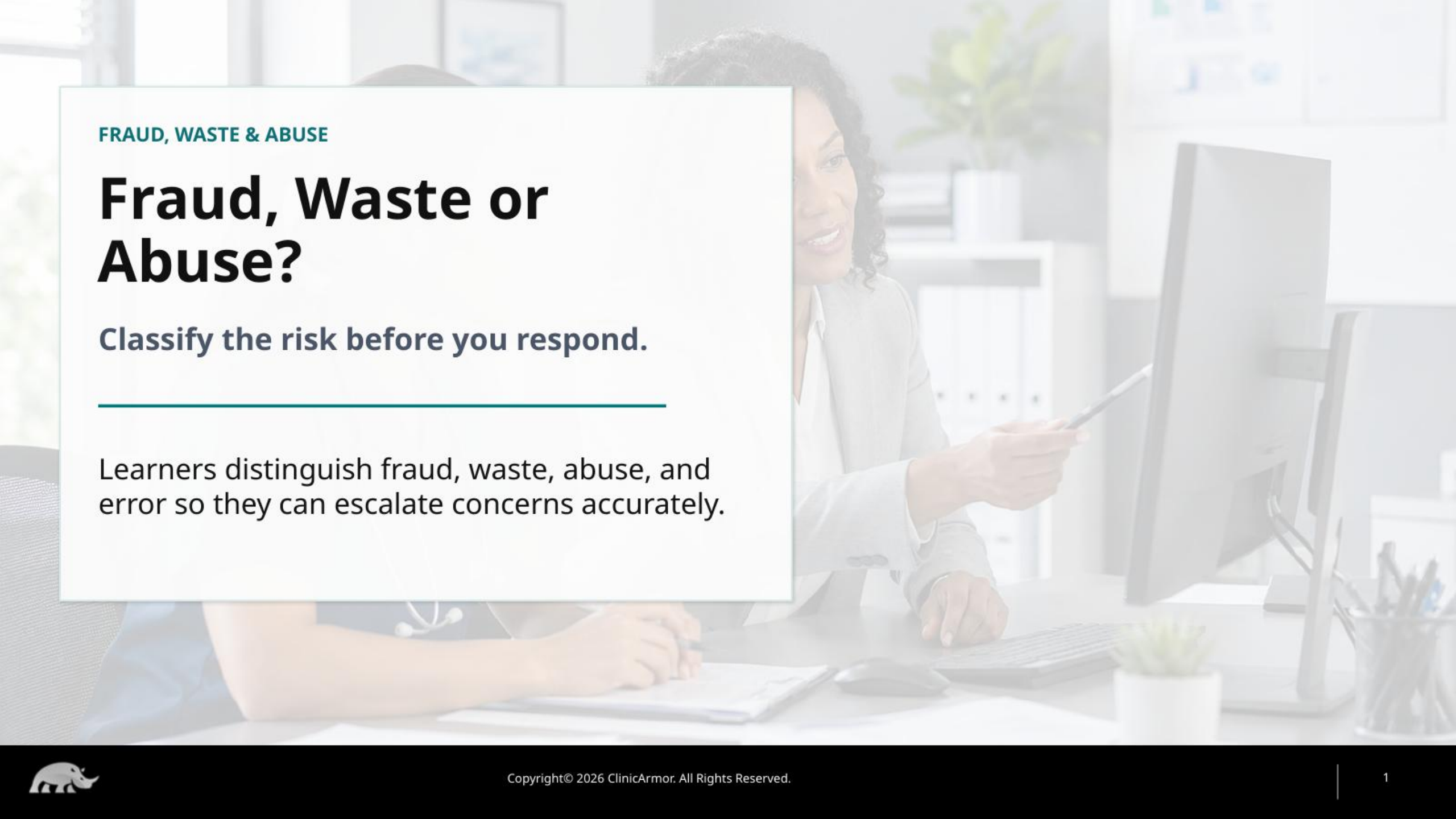
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Federal Health Care Regulations

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



A blurred background image of a healthcare professional, likely a nurse or doctor, sitting at a desk with a computer monitor. The professional is wearing a light-colored lab coat and is looking at a tablet device. The desk has a keyboard, a mouse, and some papers. The overall tone is professional and clinical.

FRAUD, WASTE & ABUSE

Fraud, Waste or Abuse?

Classify the risk before you respond.

Learners distinguish fraud, waste, abuse, and error so they can escalate concerns accurately.



Same neighborhood. Different intent.

Fraud, waste, abuse, and error are related—but not interchangeable.



Lesson 2: Fraud, Waste or Abuse?

DEFINITIONS

The Four Buckets

- Fraud: knowing misrepresentation for payment
- Abuse: conduct creating unnecessary cost without proving intent
- Waste: unnecessary cost from misuse or overuse
- Error: mistake, negligence, or misunderstanding



Lesson 2: Fraud, Waste or Abuse?

INTENT MATTERS

The Key Word Is “Knowingly”

When the issue involves false information submitted knowingly—or with deliberate ignorance or reckless disregard—the risk escalates dramatically.



Lesson 2: Fraud, Waste or Abuse?

DECISION PATH

Classify Before You Act

1 What happened?

Identify the conduct.

2 Was it supported?

Check documentation and rules.

3 Was it intentional?

Look for knowledge or pattern.

4 Escalate

Report uncertainty early.

Uncertainty is a reason to ask—not a reason to continue.



The Starting Point: Knowledge of the Law

Healthcare providers are expected to know the rules that apply to the claims they submit.

"I didn't know" is not a compliance strategy.

- ✓ **Published coverage rules**
- ✓ **Medicare regulations and policies**
- ✓ **Accepted local standards**



The Five Laws on the Radar

You do not need to memorize every statute today. You do need to recognize when a situation may touch one of them.

FCA**False Claims Act**

False or unsupported claims

AKS**Anti-Kickback Statute**

Value exchanged for referrals

Stark**Physician Self-Referral**

DHS + financial relationship

Exclusions**Exclusion Authorities**

Do not employ or bill through excluded parties

CMPL**Civil Monetary Penalties**

Administrative penalties for prohibited conduct

Memory hook: claims, kickbacks, referrals, exclusions, penalties.



False Claims Act



FRAUD, WASTE & ABUSE

Every Claim Tells a Story

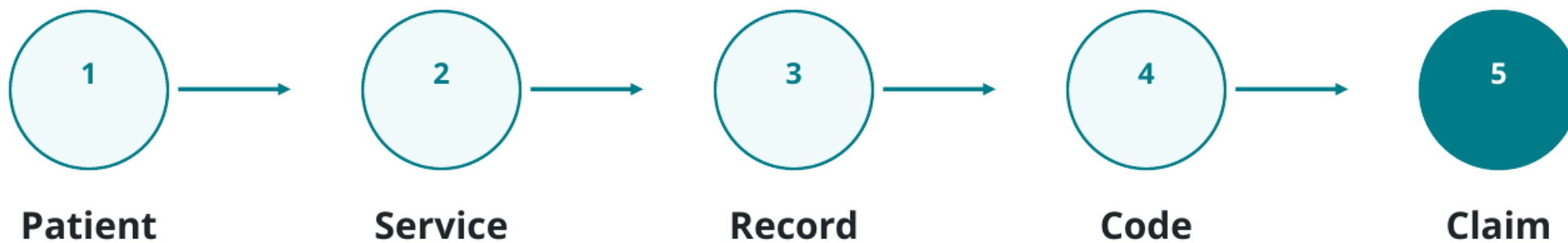
Make the claim match the care.

Learners connect the patient encounter, medical record, code, and claim before billing.



A Claim Has a Chain

A clean claim starts long before the billing screen.



If one link is weak, the claim becomes harder to defend.



Lesson 3: Every Claim Tells a Story

CLAIM CHAIN

The Claim Starts Before Billing



The claim is only as strong as the weakest link.



The Claim Form Promise

Submitting a claim certifies more than a dollar amount.



True

Accurate and complete information.



Necessary

Medically indicated for the patient.



Furnished

Personally furnished or properly incident-to.



Compliant

Follows laws, regulations, and program instructions.

Plain English: do not send a claim unless the record can back it up.



Everyone Touches the Risk

Fraud, waste, and abuse prevention is not just a billing-department responsibility.

Provider

Documents and validates medical necessity

Clinical Staff

Captures accurate visit information

Billing/Coding

Matches codes to the record and payer rules

Front Desk

Handles demographics and patient responsibility

Leadership

Sets policy, audits, and corrects gaps



Ask: “What part of the claim story do I influence?”



Before You Bill: The Six-Question Check

Use this mental checklist before a claim is released.

- 1 Was the service actually performed?
- 2 Is it documented for this date?
- 3 Is medical necessity supported?
- 4 Does the code match the service?
- 5 Is the correct provider identified?
- 6 Are payer and patient-responsibility rules followed?

When the answer is unclear, pause and ask before submitting.



Mistake or Misconduct?

Not every error is fraud. But ignoring known problems is dangerous.

Error

A mistake or misunderstanding that still must be corrected.

Fraud Risk

Actual knowledge, deliberate ignorance, or reckless disregard.

Safe response: **Find it → Report it → Correct it → Prevent it**



Red Flags Before Submission

These issues should stop the claim until reviewed.

- | | |
|---|--|
|  Service not documented |  Upcoding or unbundling |
|  Wrong provider ID |  Modifier not supported |
|  Routine copay waiver |  Code chosen to avoid coverage rules |
|  Cloned/default note |  Overpayment not resolved |

Red flag rule: pause before payment becomes the problem.



Lesson 3: Every Claim Tells a Story

PROVIDER DUTY

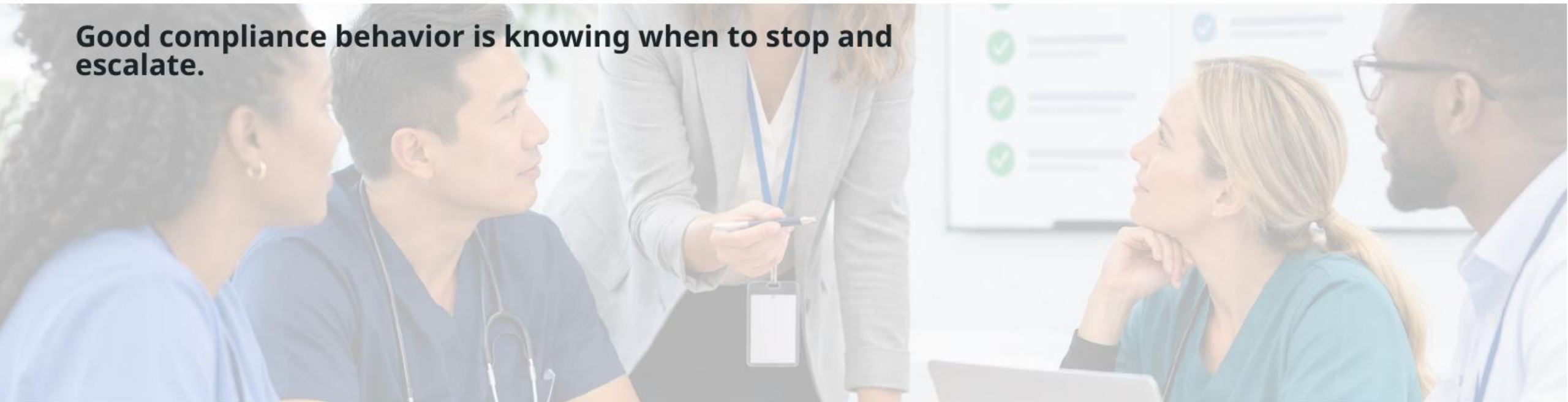
The Signature Has Meaning

Submitting a claim certifies that the services are true, accurate, medically necessary, and personally furnished or properly supervised.



When You Are Unsure, Do Not Guess

Good compliance behavior is knowing when to stop and escalate.



The goal is not perfection. The goal is a reliable correction process.



Practice Scenario: The Mismatch

A biller sees this situation before the claim goes out:

The note describes a brief follow-up visit with minimal change.

The billing screen shows a higher service level than the note appears to support.

What should happen next?

- A. Submit it; the provider probably meant it.
- B. Downcode without asking.
- C. Pause and clarify with the provider or compliance process.

Expected answer: C — pause, clarify, and document the resolution.



Lesson 2: Fraud, Waste or Abuse?

PRACTICE SCENARIO

A claim was submitted with a higher-level code than the note supports. The biller says, "That is how we always do it."

What bucket?

Expected response

Potential abuse or fraud risk depending on knowledge and pattern. Stop the pattern, review documentation, notify the responsible compliance contact, and correct any overpayments.



Lesson 3: Every Claim Tells a Story

PRACTICE SCENARIO

A provider performed one service, but the claim uses a different code because the covered code is not payable for that patient.

What breaks?

Expected response

The code no longer matches the service. Code to the highest level of specificity and follow coverage/payment rules rather than substituting a code to obtain payment.



COMMON CLUES

Red Flags That Need a Pause

- "Everyone bills it this way."
- "The payer never checks."
- "Just copy the last note."
- "Use the code that pays."
- "Do not document that part."
- "The patient will not know."



Lesson 3: Every Claim Tells a Story

FCA RISK

False Claim Patterns

- Services not performed
- Services not requested
- Services not medically necessary
- Falsified chart notation
- Upcoding or unbundling
- Wrong rendering provider or supervision



Lesson 3: Every Claim Tells a Story

BEFORE SUBMISSION

The Three Questions

- Did the service happen?
- Does the record support it?
- Does the code accurately describe it?



The note is the evidence.

If it is not clear in the record, it may not support the claim.



Lesson 4: Documentation Is Your Evidence

CORE PRINCIPLE

Document the Patient—Not the Template

Templates should prompt clinical thinking. They should not replace specific findings, changes, decisions, and medical necessity for the current visit.



Lesson 4: Documentation Is Your Evidence

RISK AREAS

Documentation Gaps That Matter

- Treatment plan missing
- Mechanism of trauma not identified
- Subluxation or diagnosis not supported
- Changes since last visit missing
- Treatment effectiveness not validated
- Signature or scribe requirements not met
- Medical necessity unclear
- Modifier need not documented



Lesson 4: Documentation Is Your Evidence

CLONED NOTES

Copying Can Look Like Knowing

Repeated default language makes it difficult to tell what actually happened during the current visit and may suggest intentional unsupported billing.



Lesson 4: Documentation Is Your Evidence

CURRENT VISIT NOTE

What Should Change Visit to Visit?

1 Symptoms

Current status and change.

2 Findings

Relevant exam evidence.

3 Decision

Why this care today?

4 Response

Progress or lack of progress.

Medical necessity is a thinking process—not a word count.



Lesson 4: Documentation Is Your Evidence

PRACTICE SCENARIO

Every follow-up note says the patient is “improving,” but pain, function, exam findings, and care plan never change.

What is missing?

Expected response

The record lacks current-visit specificity and treatment effectiveness. Update the note with real findings, functional progress, clinical reasoning, and any plan changes.



A clean note protects the patient and the practice.

ASSIGNMENT

Review one de-identified note and mark where it supports the service, medical necessity, provider identity, and change since last visit.



Lesson 9: Find It. Fix It. Prevent It.

POLICY GAP ANALYSIS

Fix the System, Not Just the Claim

Corrections should address root cause: unclear policy, inadequate training, EHR template problems, supervision gaps, or missing audit processes.



Anti-Kickback

FRAUD, WASTE & ABUSE

Nothing of Value Is Just “Nothing”

Spot Anti-Kickback risk before it becomes a deal.

Learners recognize remuneration, inducement, and referral-risk patterns.



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

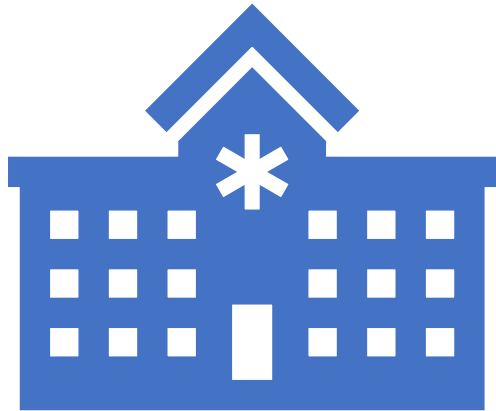
U.S. Department of Justice
vs Dr. Friendly

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.

**This has
to stop.**

**Providing services
at no charge to
Medicare/Medicaid
Patients**

Value changes the risk.

In federal healthcare, “free” can become evidence.



Lesson 5: Nothing of Value Is Just “Nothing”

ANTI-KICKBACK STATUTE

Anything of Value Counts

Remuneration is not just cash. It can be gifts, free services, waived cost-sharing, space, equipment, discounts, consulting fees, or other benefits.



Lesson 5: Nothing of Value Is Just “Nothing”

RISK SCREEN

Four Questions Before You Say Yes

- Who receives the value?
- Why are they receiving it?
- Can they influence referrals?
- Is it tied to federal program business?



Lesson 5: Nothing of Value Is Just “Nothing”

ARRANGEMENT REVIEW

Pause the Deal

1 Identify

What is being offered?

2 Connect

Is there referral influence?

3 Value

Is it fair market value?

4 Document

Is there a written, legitimate purpose?

When one purpose is referrals, risk rises.



Lesson 5: Nothing of Value Is Just “Nothing”

PRACTICE SCENARIO

A vendor offers free equipment to the practice because the practice “sends good patients” and may order more supplies later.

Safe or stop?

Expected response

Stop and escalate. The item has value, the vendor may receive federal program business, and the offer may be linked to past or future referrals or orders.



Lesson 5: Nothing of Value Is Just “Nothing”

COMMON INDUCEMENTS

Watch These Patterns

- Free services to Medicare patients
- Routine copay waivers
- Below-market rent or space
- Excessive medical director fees
- Gift cards or cash equivalents
- Referral-based perks



Anti-Kickback Red Flag Check

☐

Anything of value?

☐

Referral source?

☐

Federal payer?

☐

Fair market value?

☐

Written agreement?

☐

Clinical judgment protected?



Stark Law

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

FRAUD, WASTE & ABUSE

Follow the Money

Recognize Stark and self-referral triggers.

Learners know when a referral plus a financial relationship needs legal/compliance review.



Referral + Financial Relationship = Stop and Ask

Stark concerns are triggered by structure—not just intent.



STARK LAW

The Self-Referral Trigger

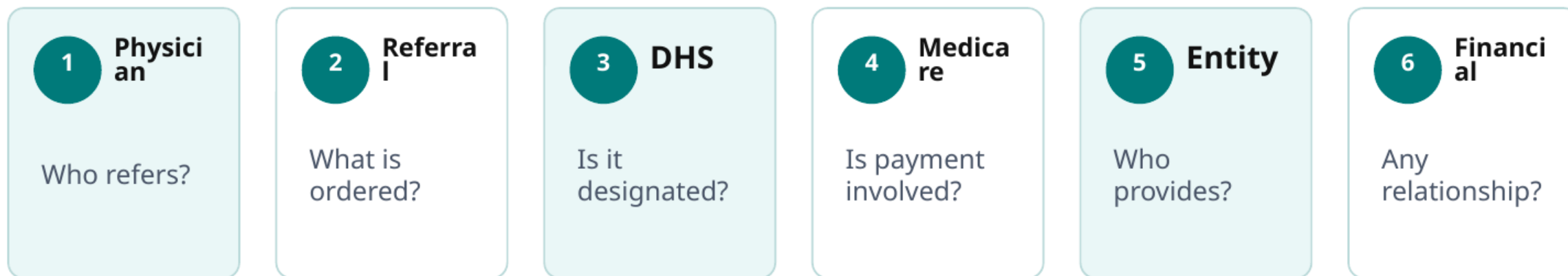
A physician referral for designated health services payable by Medicare to an entity with a physician or family financial relationship requires careful review.



Lesson 6: Follow the Money

SIX ELEMENTS

The Stark Screen



If all elements appear, do not guess—escalate.



DESIGNATED HEALTH SERVICES

Common DHS Examples

- Clinical laboratory services
- Physical therapy services
- Radiology and imaging
- DME and supplies
- Home health services
- Outpatient prescription drugs



Lesson 6: Follow the Money

STRICT LIABILITY

Good Intent Is Not the Test

Stark is generally treated as strict liability. A well-meaning referral can still be a problem if the arrangement does not fit an exception.



Lesson 6: Follow the Money

PRACTICE SCENARIO

A doctor refers Medicare patients to an imaging company owned by an immediate family member.

What should happen?

Expected response

Pause and refer for legal/compliance review. There may be a financial relationship and a designated health service payable by Medicare.



Referral Relationship Check

☐ Any ownership?

☐ Any compensation?

☐ Immediate family?

☐ DHS involved?

☐ Medicare payable?

☐ Exception reviewed?



Do not map the referral after the audit.

ASSIGNMENT

Create a simple map of outside entities your practice commonly refers to, and identify any known ownership, family, or compensation relationships.



FRAUD, WASTE & ABUSE

Free Can Be Expensive

Discounts, gifts, waivers, and professional courtesy.

Learners identify when generosity, marketing, or convenience can create FWA risk.



Nice intentions can still create risk.

Free care, discounts, and gifts need rules—not improvisation.



Professional Courtesy



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



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

What does the OIG say about Professional Courtesy?



“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* bill
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))



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 to Patients What does the OIG say about this?



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).

Gifts from Vendors



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 to patients who receive significant services.
 - ✓ Gifts that are given shortly after significant services were provided.



ClinicArmor™

COMPLIANCE. PROTECTION. CONFIDENCE.

Financial Policy in Practice

Know Your Numbers. Explain the Policy. Protect the Practice.

Practical compliance training for medical providers, billing teams, and front-office staff.

Core principle: your financial policy should be accurate, consistent, documented, and easy for patients and staff to understand.



Seven lessons that turn financial policy into daily practice

- 1 Know Your Numbers**
Understand cost, overhead, and visit economics before setting fees.
- 2 Know Your Agreements**
Review payer contracts, fee schedules, updates, and obligations.
- 3 Set Fees Carefully**
Build UCR/actual fees without competitor price discussions.
- 4 Discount the Right Way**
Use contractual, prompt-pay, hardship, and documented discounts consistently.
- 5 Put It in Writing**
Create a clear financial policy patients and staff can actually use.
- 6 Train the Team**
Use role-based training and scripting for consistent conversations.
- 7 Keep It Current**
Audit, update, and avoid coding, discounting, and documentation traps.

Learner habit: stop improvising financial conversations — use the policy, the numbers, and the documented process.



Know Your Numbers

Financial policy starts with reality.

Before setting fees, discounts, or payment options, the practice should know what each visit costs to deliver.

No numbers → no reliable policy



Know Your Numbers

The core calculation

Average monthly overhead

Total operating cost

Average monthly visits

Visit volume

Average income per visit

Actual collection pattern

Cost to deliver one visit

**Average Monthly Overhead ÷
Average Monthly Visits**

Why it matters

If the practice collects less than it costs to deliver the visit, the fee policy may look patient-friendly but operate at a loss.

Use the number to evaluate contracts, discounts, and business sustainability.



Build a Numbers Habit

- ✓ Average monthly overhead
- ✓ Average monthly visits
- ✓ Average income per visit
- ✓ Average monthly income
- ✓ Cost to deliver one visit
- ✓ Percentage overhead
- ✓ Top reimbursed services
- ✓ Services paid below cost

Use your own numbers before changing fees, contracts, or discounts.



Know Your Agreements

Your payer contracts are operating rules.

- ✓ Review provider agreements regularly.
- ✓ Identify covered and non-covered services.
- ✓ Track fee schedule and policy updates.
- ✓ Make sure billing staff know the contract obligations.

Practice question

Do we know what each payer requires?
Do we know when agreements can be changed or terminated?



Contract Review Checklist

- ✓ Current payer contract on file
- ✓ Latest fee schedule attached
- ✓ Covered service list reviewed
- ✓ Non-covered service rules identified
- ✓ Notice/update process assigned
- ✓ Termination or renegotiation terms known
- ✓ Billing team trained on key rules
- ✓ Annual review date scheduled

A contract you do not review is a contract you cannot manage.



Lesson 7: Free Can Be Expensive

FINANCIAL POLICY

Start With One Fee Schedule

A sound financial policy begins with a clear fee schedule and defined, consistently applied discount categories.



Set Fees Carefully

Your fee is your fee.

Set an actual fee schedule based on your practice data, market information, and published fee schedules — not informal competitor conversations.

One actual fee schedule



Do Not “Phone a Friend” About Fees

- ✓ Do not ask competitors what they charge
- ✓ Do not agree with competitors to maintain fees
- ✓ Use lawful data sources and consultants appropriately
- ✓ Use published fee schedules where applicable
- ✓ Review your own cost and payer data
- ✓ Document how fees were evaluated

Fee decisions should be independent, documented, and legally reviewed when needed.



A Safer Fee-Setting Process



Keep the policy simple enough to explain — and strong enough to defend.



Discount the Right Way

Discounts need rules, not improvisation.

- ✓ Contractual discount: based on payer agreement.
- ✓ Mandated discount: based on state/federal program rules.
- ✓ Prompt-pay discount: tied to documented savings.
- ✓ Hardship discount: based on verified need and limited duration.

Red flag

“We just give this patient a special rate.”
“They have always paid the old fee.”



Hardship Is a Process

Compassion still needs documentation.

A hardship policy should use defined criteria, an application, proof of need, approval, expiration, and re-evaluation.

Apply → Verify → Approve → Expire



GIFTS AND MARKETING

Ask Before You Give

- Is the person a referral source?
- Is the person a federal beneficiary?
- Is it cash or a cash equivalent?
- Is it tied to past or future business?
- Why this person and not others?
- Is it within current policy limits?



Generosity needs guardrails.

ASSIGNMENT

Collect one current discount, coupon, free service, or courtesy practice and compare it to the written financial/professional courtesy policy.



ALLOWED DISCOUNT CONCEPTS

Discounts Need a Legal Basis

- Contractual payer rates
- Prompt payment policy
- Legislated fee schedules
- Documented financial hardship
- Valid discount medical plan
- Reasonable collection efforts



Lesson 7: Free Can Be Expensive

COPAY WAIVERS

Routine Waivers Are Dangerous

Waiving patient responsibility without a defined policy can look like an inducement, a false billed amount, or inconsistent financial treatment.



Lesson 7: Free Can Be Expensive

PRACTICE SCENARIO

A practice gives free therapy to Medicare patients so the care plan feels more affordable, then bills covered services around it.

What is the concern?

Expected response

The free service may be viewed as an inducement to receive covered services. Stop and review with compliance before using free services in any federal beneficiary promotion.



Discount Control Questions

- ✓ What type of discount is this?
- ✓ What policy authorizes it?
- ✓ Is it consistent with payer contracts?
- ✓ Is patient eligibility documented?
- ✓ Is there an expiration date?
- ✓ Is the amount tied to approved criteria?
- ✓ Is staff trained to apply it consistently?
- ✓ Is the discount visible in the record?

A discount without a policy becomes a risk.



Put It in Writing

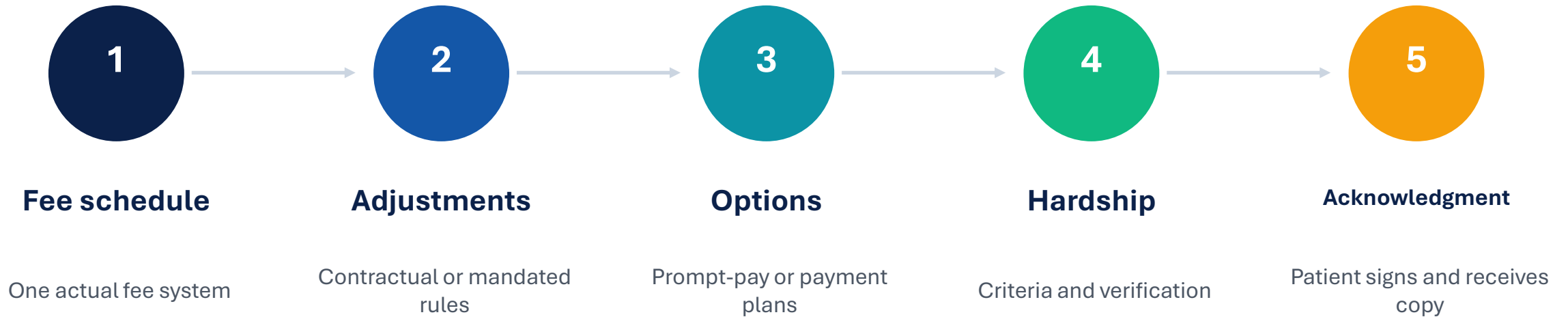
A good policy is short enough to use.

Patients and staff should understand the financial policy without needing a binder, a manager, or a legal dictionary.

Clear policy = consistent conversations



What the Policy Should Cover



Keep the policy simple enough to explain — and strong enough to defend.



Financial Report of Findings

Explain money after the clinical plan is clear.

- ✓ Provider explains diagnosis and treatment recommendations.
- ✓ Patient agrees to the clinical plan.
- ✓ Trained staff explains coverage, patient responsibility, and payment options.
- ✓ Patient receives a clear next step.

The goal

Reduce fear.
Prevent surprises.
Support informed financial decisions.



Train the Team

Policy fails when staff improvise.

Every team member who speaks with patients should know the financial policy and how to explain it consistently.

Train it. Script it. Practice it.



Role-Based Training Topics

- ✓ HIPAA basics before patient access
- ✓ OSHA and safety expectations
- ✓ Fraud, waste, and abuse reporting
- ✓ Financial policy and scripts
- ✓ Discount and hardship rules
- ✓ Billing handoff workflow
- ✓ Patient payment conversations
- ✓ Escalation to manager/compliance

Do not let the first patient question be the first time staff practice the policy.



Scripts Build Consistency

Use scripts as guardrails.

- ✓ Staff answer common questions the same way.
- ✓ Patients hear accurate, respectful explanations.
- ✓ Payment conversations become less uncomfortable.
- ✓ Managers can coach and improve language over time.

Script rule

Never promise coverage.
Never invent a discount.
Never blame the payer or patient.



Keep It Current

A financial policy is not a one-time project.

Review fees, payer agreements, discount schedules, hardship criteria, and staff training at least annually and when major changes occur.

Calendar it or it will drift



Things to Avoid

- ✓ Coding based on desired payment
- ✓ Discounting outside written policy
- ✓ Downcoding to make care affordable
- ✓ Upcoding for higher reimbursement
- ✓ Outdated fee schedules
- ✓ Unverified hardship discounts
- ✓ Staff making special deals
- ✓ Documentation that does not support the charge

Compliance breaks when the policy says one thing and the practice does another.



Annual Financial Policy Tune-Up



Keep the policy simple enough to explain — and strong enough to defend.



The Daily Financial Policy Checklist

- ✓ Know the cost of care
- ✓ Know the payer rules
- ✓ Use one actual fee schedule
- ✓ Apply only approved discounts
- ✓ Document hardship decisions
- ✓ Explain financial responsibility clearly
- ✓ Train staff to use scripts
- ✓ Review and audit the policy annually

Know your numbers. Explain the policy. Protect the practice.



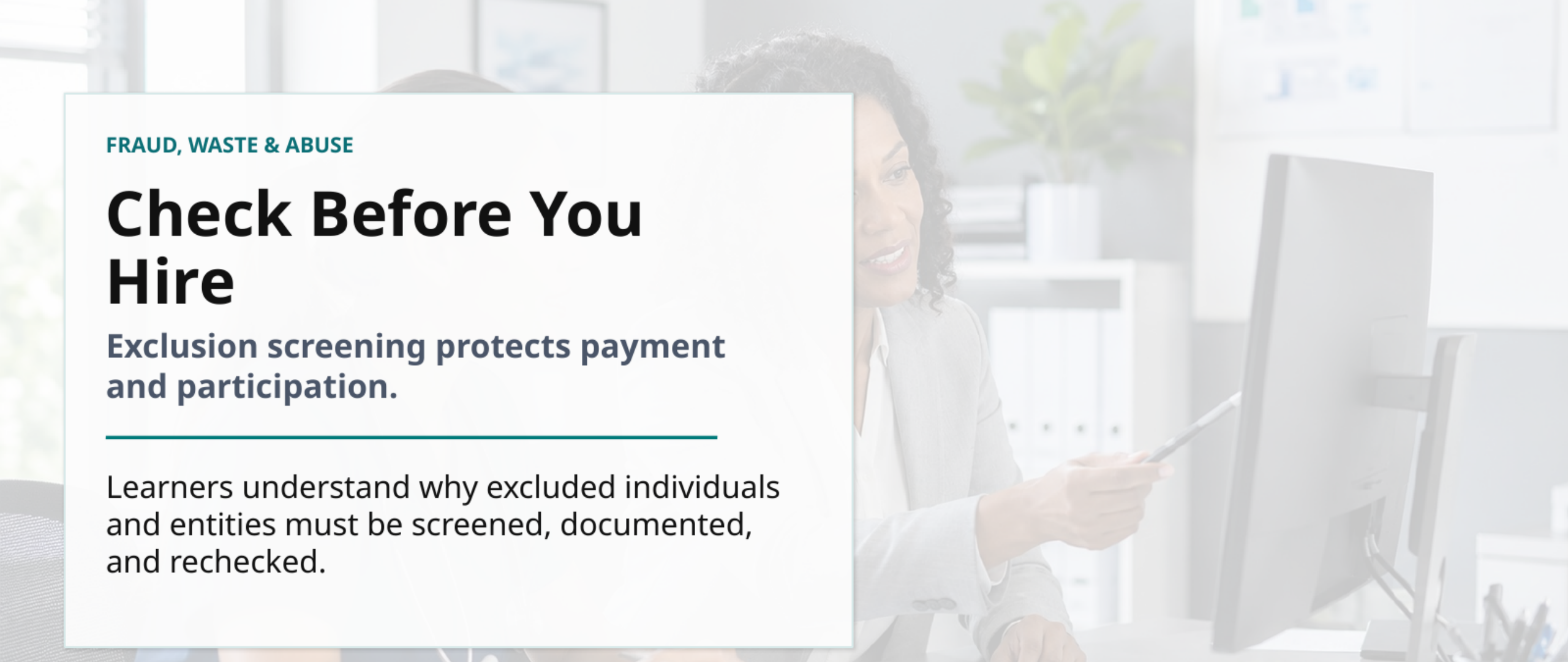
The OIG Exclusion List



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.





FRAUD, WASTE & ABUSE

Check Before You Hire

Exclusion screening protects payment and participation.

Learners understand why excluded individuals and entities must be screened, documented, and rechecked.

Excluded means no federal payment.

You cannot fix exclusion risk after the claim is paid.



Lesson 8: Check Before You Hire

EXCLUSION AUTHORITY

Who Must Be Screened?

Employees, contractors, vendors, owners, managers, and others who furnish, order, prescribe, direct, or support federally reimbursed items or services may require screening.



Exclusion Screening Check

☐ Pre-hire screen?

☐ Contractor screen?

☐ State list checked?

☐ Results documented?

☐ Repeat schedule?

☐ Match escalation process?



<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

Lesson 8: Check Before You Hire

PRACTICE SCENARIO

A new contractor begins helping with services before exclusion screening is completed. Claims are submitted during that period.

What is the issue?

Expected response

The practice may have payment and overpayment risk if the individual or entity is excluded. Pause, screen immediately, document the result, and escalate any match.



A problem found early is a problem you can control.

Silence turns small issues into patterns.



Lesson 9: Find It. Fix It. Prevent It.

RESPONSE PATHWAY

STOP → REPORT → INVESTIGATE → CORRECT → MONITOR

1 Stop

Prevent more claims.

2 Report

Notify the right person.

3 Investigate

Find scope and cause.

4 Correct

Fix claims and process.

5 Monitor

Confirm it stays fixed.

Correction is a compliance function—not blame.



Lesson 9: Find It. Fix It. Prevent It.

OVERPAYMENTS

Do Not Sit on Known Problems

When an overpayment is identified, the practice must follow its refund and reporting process promptly and document the corrective action.



Questions or Comments

Info@ClinicArmor.com



Part II:

Documentation Requirements



Coding & Documentation Guidelines

Document It. Code It. Prove It.

Practical compliance training for healthcare providers and staff

Your documentation is the evidence that links care, coding, medical necessity, and payment.



Medicare Documentation

Key compliance issues...

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.

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.

Comprehensive Error Rate Testing Program (CERT)

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 1st quarter 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>

Q3 2025

Chiropractic Services

CERT finding	Resolution	Resource(s)
Documentation to support medical necessity is inadequate.	Medical record documentation must include a treatment plan.	Novitas: Billing and Coding: Chiropractic Services (A58345)
Missing medical necessity supporting active/corrective treatment.	Medical record documentation must demonstrate active or corrective treatment.	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



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%

2024 Medicare Fee-for-Service Supplemental Improper Payment Data

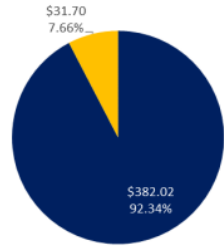
file:///C:/Users/scott/OneDrive/Desktop/nov-2024-medicare-ffs-supplemental-improper-payment-data_2024920.pdf

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)



■ Proper Payments ■ Improper Payments

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

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

Standard of Care Needs Proof

If it is not documented clearly, others may not be able to see what you did.



? The practical test

Could another reviewer understand the clinical reasoning, the patient need, the treatment provided, and the code submitted?

✓ The habit to build

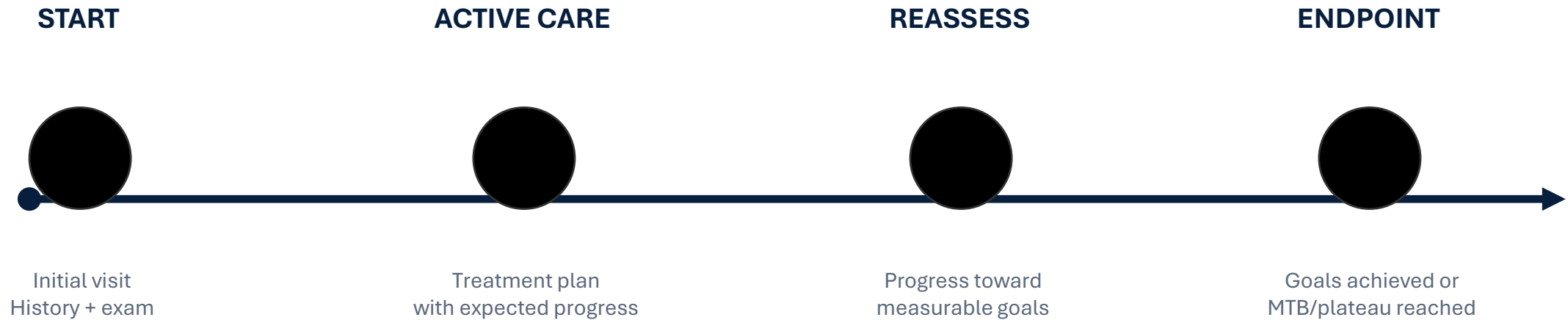
Write documentation that is specific, measurable, timely, and tied to the patient's actual condition on that date.

Defining an Episode of Care

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

Start With the Episode of Care

Every episode needs a beginning, a planned path, and an endpoint.



The initial visit sets the clinical map. Subsequent visits prove whether the patient is moving along it.



Active Treatment vs. Maintenance

Know whether care is corrective, supportive, or clinically appropriate but not covered.

Active Treatment

Treatment for a new or worsening condition where improvement, arrest of progression, or functional gain is expected.

Maintenance / Supportive Care

Care designed to maintain health, prevent deterioration, or support quality of life after further improvement is not expected.

The record should show when active care begins, how progress is measured, and when the endpoint is reached.

- Treatment plan required for active care
- Specific goals help identify the endpoint
- Maintenance may be clinically appropriate but must be clearly distinguished



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 Initial Visit Framework

Build the record in three connected blocks.

1 History

Chief complaint, HPI, mechanism, ROS, PFMSH, outcome assessments, and functional limitations.

2 Examination

Vitals when indicated, orthopedic, neurologic, palpatory, biomechanical, imaging, and other diagnostic findings.

3 Clinical Decision

Diagnosis, medical necessity, treatment plan, goals, duration, frequency, self-care, and signature.

The strongest initial visit shows correlation: complaint → mechanism → exam → diagnosis → plan.



HPI: Tell the Origin Story

Mechanism, onset, and symptom behavior help prove causation and necessity.

- Mechanism of trauma or insidious onset
- Location and date of onset
- Quality, intensity, duration, frequency
- Radiation, aggravation, palliation
- Prior interventions and response

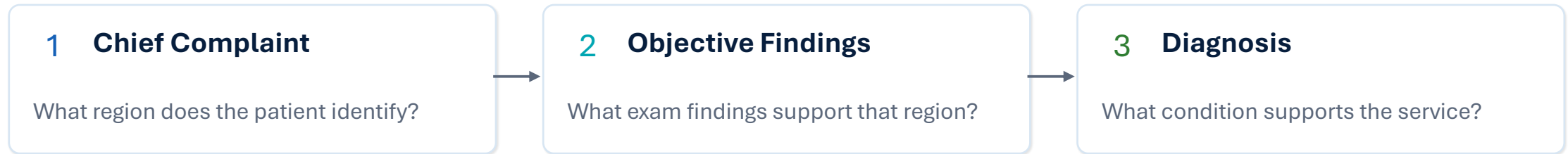


When cause is unknown, document what you ruled out — not just “insidious onset.”

Chief Complaint = Region of Involvement

Each region billed or treated needs support in the record.

For each region, ask:



If three or four regions are billed, the record should support three or four regions independently.



Fill the Gap in Care

When treatment is delayed, the record should explain the bridge from injury to today.

Key question: “Why was treatment not sought during this time?”

- Was the patient experiencing symptoms?
- Were medications used?
- Were any providers seen?
- Were activities or lifestyle changed?
- Did anyone advise the patient about symptoms?

INJURY / ONSET

TODAY'S EXAM



**History fills the space
between.**



Look Beyond the Pain Complaint

ROS, PFMSH, and barriers help explain complexity and recovery risk.

ROS Review of Systems

Identify body systems or symptoms that may affect diagnosis, referral, or treatment planning.

H PFMSH

Past, family, medical, and social history may reveal comorbidities, prior care, medications, or lifestyle factors.

🚩 Barriers to Care

Work demands, disability, psychological factors, transportation, and insurance may influence recovery.

Document factors that may complicate recovery, change risk, or explain slower progress.



History
Examination
Clinical
Decision
Making

Initial Visit Documentation Requirements

Examination Must Correlate

Objective findings should connect back to the complaint and mechanism.

1 Vitals

Rule out underlying concerns when indicated

2 ROM

Measure restriction or abnormal motion

3 Ortho / Neuro

Reproduce or localize tissue involvement

4 Palpation

Quantify tenderness, tone, and segmental findings

5 Imaging / Labs

Use when ordered or clinically indicated

The question is not “Did we do tests?” It is “Do the findings support the diagnosis and plan?”



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?**

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

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

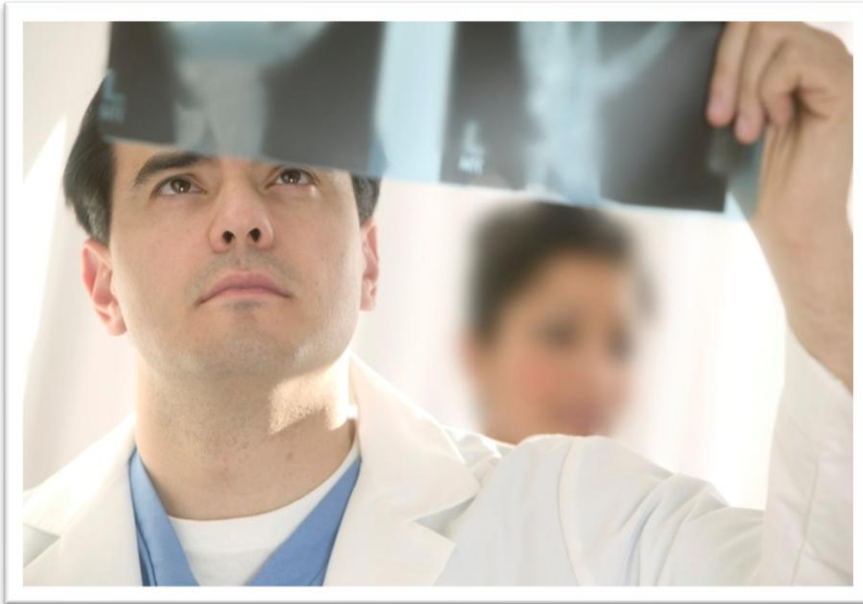
**Initial Visit
Medicare
Requirement**

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:



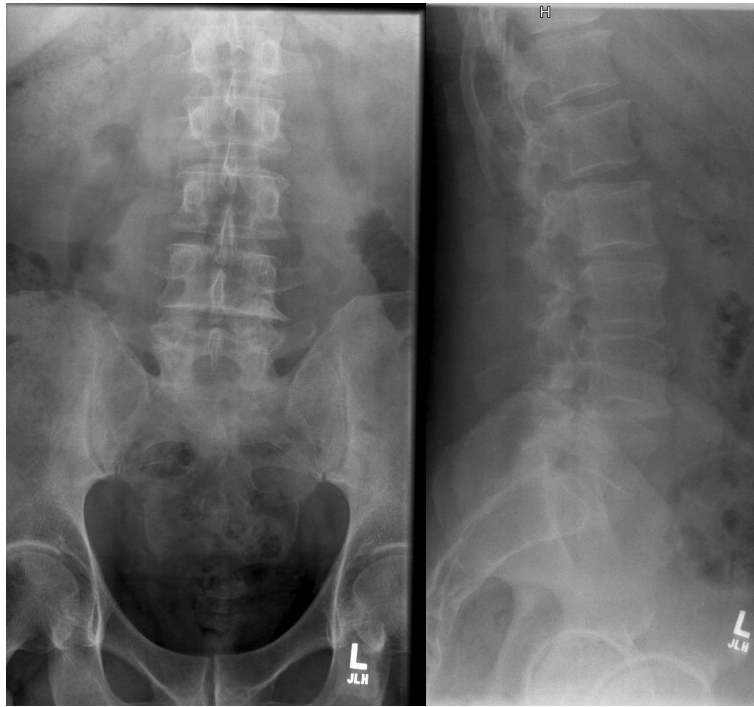
- ✓ X-ray
- ✓ Physical Examination

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



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

Pain/Tenderness

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

Quantify Objective Findings

Use repeatable scales when possible so progress is visible.

T Tenderness

Example: +2 to +1, or severe to moderate if your scale is defined.

S Tone / Spasm

Example: 4/5 to 2/5 hypertonicity when your practice defines the scale.

R Range / Function

Example: 25° to 40°, walking 20 minutes to 35 minutes.

Measuring the same thing over time is how you demonstrate treatment effectiveness.

- Define your internal scales so providers use them consistently.
- Measure findings tied to the chief complaint and diagnosis.
- Use objective updates to support progress evaluations and discharge decisions.



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

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

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)

Arriving at a
diagnosis and
Treatment Plan
involves using
Decision Support
Tools, Critical
Thinking
Processes, and an
Evidence-informed
Approach.

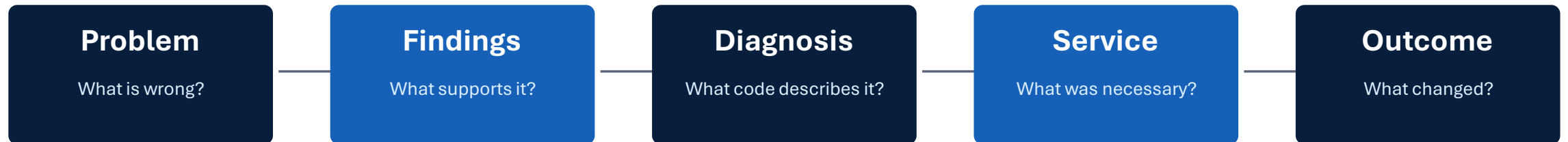
Medical Decision Making

Differential Diagnosis

Diagnosis Supports Necessity

Medical necessity is the bridge from problem to service.

Reasonable and necessary services are tied to diagnosis, treatment, function, and documented findings.



- Follow payer and LCD requirements where applicable.
- Sequence codes thoughtfully and support each billed region.
- Avoid using pain codes as a substitute for clinical thinking when a more specific diagnosis is known.



Know When to Stop and Refer

Red flags change the decision from treat to protect.



! Immediate Referral Signals

Fracture/dislocation, cancer, infection, instability, severe hypertension, visceral pathology, or other serious findings.

⚠ Cautious Considerations

Osteoporosis, anticoagulants, prior surgery, spinal stenosis, psychiatric disorder, and other factors may require modification.

Documentation should show how risk was recognized, ruled out, referred, or managed safely.

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.

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 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!

**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?**

Barriers to Care

**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 (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.

National Coverage Determinations and Local Coverage Determinations

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: Three Things

Goals, duration, and frequency make the endpoint visible.

1 Specific Measurable Goals

Pain, function, and objective findings stated with numbers whenever possible.

2 Duration of Care

How long it is expected to take to reach the goals or maximum therapeutic benefit.

3 Total Frequency

How many visits are expected within the duration of care.

A treatment plan should let the patient, payer, and provider know what “done” looks like.



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

**What level of
improvement do
you expect to
achieve?**

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**

Make Goals Measurable

“Better” is not a goal. A number is.

✗ Weak Goal

Decrease pain, increase ROM, improve function.

✓ Strong Goal

Sleep 5 hours without waking; reduce VAS from 8 to 4; improve cervical rotation from 25° to 50°.

Use numbers: pain score, patient-specific function, duration, distance, degrees, or other measurable endpoints.

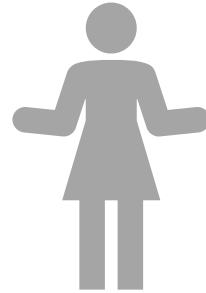
- Anchor goals to pre-incident status when appropriate.
- Connect the goal to the region and mechanism of injury.
- Use outcome tools to support necessity, but do not rely on them as the only goal.



Goal Categories



PAIN GOAL



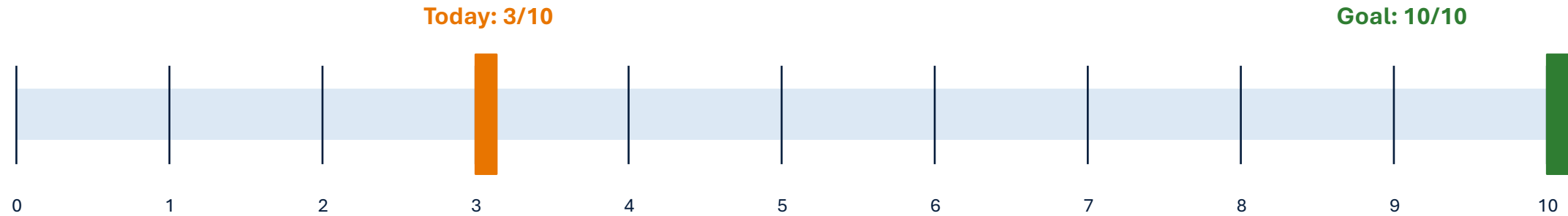
ACTIVITY OF DAILY
LIVING (SPECIFIC
FUNCTIONS)



RANGE OF MOTION

Function Is King

Pain matters, but function shows whether the patient's life is improving.



Patient-Specific Functional Scale: ask the patient to rate the activity they cannot do well today.

- Pick activities from the patient's history: walking, sitting, sleeping, lifting, turning, driving.
- Track the same activity across visits.
- Use the change to demonstrate treatment effectiveness.

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**.

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.

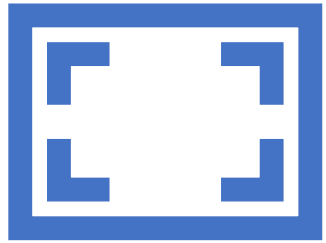
Goals:

- **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.**

Generalized vs. Specific Goal Comparison



Quantifiable and Measurable

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

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**).

DURATION OF CARE

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

FREQUENCY OF CARE

Patient-Facing Requirements Count Too

Documentation includes what the patient was told and agreed to.



Informed Consent

Completed before diagnostic or treatment procedures, after clinician-patient discussion of relevant information.



Good Faith Estimate

For uninsured or self-pay individuals when expected charges must be disclosed under applicable requirements.

Consent and financial notice workflows should be documented as part of the compliance record.



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

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

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

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

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 aforementioned 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:

.....
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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

Progress Evaluations Are Decision Points

Reassess progress toward the goals and adjust the plan when needed.



1 Compare

Previous history and exam findings against current status.

2 Measure

Progress toward specific treatment goals.

3 Decide

Continue, modify, discharge, refer, or establish a new plan.

Common rhythm: every 10–12 visits or about every 30 days, based on practice policy and clinical need.



How do we
demonstrate
treatment
effectiveness?

**Quantify and
Measure**

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

Progress Evaluations

E/M Coding: Two Main Paths

Office and outpatient E/M code selection may be based on MDM or time.

MDM Medical Decision Making

Number and complexity of problems, amount/complexity of data, and risk of management.

TIME Total Time

Total time personally spent by the reporting practitioner on the date of the encounter.

Do not let volume of words drive the code. Let supported work, complexity, or documented time drive the code.



Modifier -25: Separate Means Separate

Use only when the E/M service is significant and separately identifiable.

E/M SERVICE + **PROCEDURE** = ?

The record should show why the E/M work was significant, separate, and identifiable from the procedure.

- Do not append automatically.
- Document the separate work clearly.
- Use payer-specific rules and current coding guidance.



Subsequent Visits

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

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 C1 (atlas)), lumbo-sacral (L5 and Sacrum) sacro-iliac (sacrum and ilium).

Documentation of Subluxation Objective & Procedure Section of the note

Every Visit Must Stand on Its Own

Subsequent visit notes should prove what changed and what was done today.



S Subjective

Pain level, quality, aggravating factors, ADL limitation, and changes since last visit.

O Objective

Region-specific findings, palpation changes, treatment findings, and measurable updates.

A Assessment

Response to care, treatment effectiveness, progress toward measurable goals.

P Plan / Procedure

What was performed, by whom, where, for how long, and what patient education occurred.

The Clone Note Trap

Templates should prompt thinking—not replace it.

What reviewers see

Repeated identical notes make it difficult to know what work was actually provided for the current visit.

Why it matters

Cloned information can suggest lack of medical necessity, contradictory records, patient-care risk, or potential misrepresentation.

Document the patient — not the template.



Use the Magic Words

“Changes since last visit” keeps the note encounter-specific.

CHANGES SINCE LAST VISIT

1 Pain

What is the current score? What changed in intensity or quality?

2 Function

What specific ADL improved, worsened, or stayed the same?

3 Objective Findings

What changed in tenderness, tone, ROM, or other findings?

If nothing changed, say that — and explain what that means for the plan.



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?

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."

Erroneous, contradictory, or cloned information

Potential for fraud

Lack of medical necessity

Patient care issues

**EHR templates are meant to
prompt physician
documentation.**

Close the Record Before the Claim

Timely completion protects authenticity and reduces avoidable corrections.

**24–48
HOURS**



✓ **Recommended habit**

Complete and sign notes within 24–48 hours of the encounter and before the claim is submitted.

↻ **After closure**

Use a proper amendment or addendum process that preserves the original record.

! **Why it matters**

Late, altered, or unsupported entries can weaken authenticity and create audit questions.



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

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

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.

Aggravation or Exacerbation?

Care changes should be described accurately.

A Aggravation

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

E Exacerbation

A temporary flare-up or increase in symptoms that generally returns toward baseline.

Ask: Does this event change the current plan, require reevaluation, or simply explain a temporary setback?





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/>

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

(throwing gas on a fire)

Exacerbation

Know When the Episode Ends

Discharge when goals are achieved or therapeutic gain has plateaued.

✓ Goals Achieved

The patient reached the measurable endpoint established in the treatment plan.

— Plateau / MTB

The patient has stopped making meaningful therapeutic gains despite appropriate care.

Endpoint documentation protects the patient, the provider, and the payer relationship.

- Summarize final pain, function, and objective status.
- State whether goals were achieved, partially achieved, or not achieved.
- Document discharge, PRN, maintenance, referral, or updated treatment plan as appropriate.



Audit Before Someone Else Does

Self-audits turn documentation rules into practice habits.



1 Initial / Re-exam

History, exam, diagnosis, treatment plan, consent, coding, charge capture, and signature.

2 Subsequent Visit

Updated pain/function, objective findings, procedure detail, treatment effectiveness, and code linkage.

3 Corrective Action

Identify the pattern, fix the workflow, train the team, and monitor improvement.



The Daily Documentation Checklist

A simple memory aid for every patient record.

- ✓ **Specific to today**
- ✓ **Tied to the chief complaint**
- ✓ **Supported by objective findings**
- ✓ **Measurable goals and progress**
- ✓ **Complete before claim submission**
- ✓ **Code matches documented work**
- ✓ **Reviewed through self-audit**

Assignment: Select three recent records and audit whether the claim story is complete from patient need to code submission.

Takeaway: Document the patient. Measure progress. Code what the record supports.



Why Payers Care

Improper payments are often tied to documentation, necessity, or coding.



! Insufficient documentation

The record does not adequately support the service, code, or medical necessity.

\$ Lack of medical necessity

The service may have been performed, but the record does not show why it was reasonable and necessary.

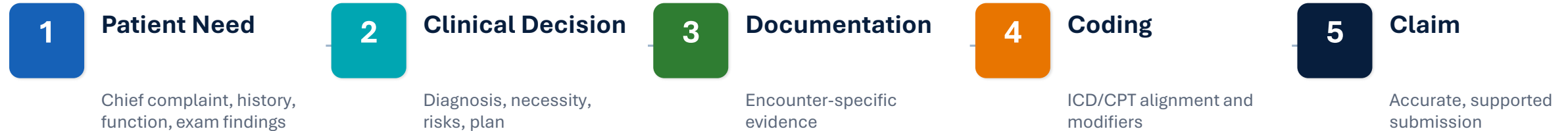
Incorrect coding

The code submitted does not match the supported level, region, service, or documented work.

The only durable defense is a record that supports the claim before the claim goes out.

Every Claim Tells a Story

The claim should match the patient, the service, the documentation, and the code.



A claim becomes vulnerable when one link in the story is missing or mismatched.

- Diagnosis must support the service.
- The service must be documented for that date.
- The code must match the documented work.
- The claim must be submitted only after the record is complete.



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.**

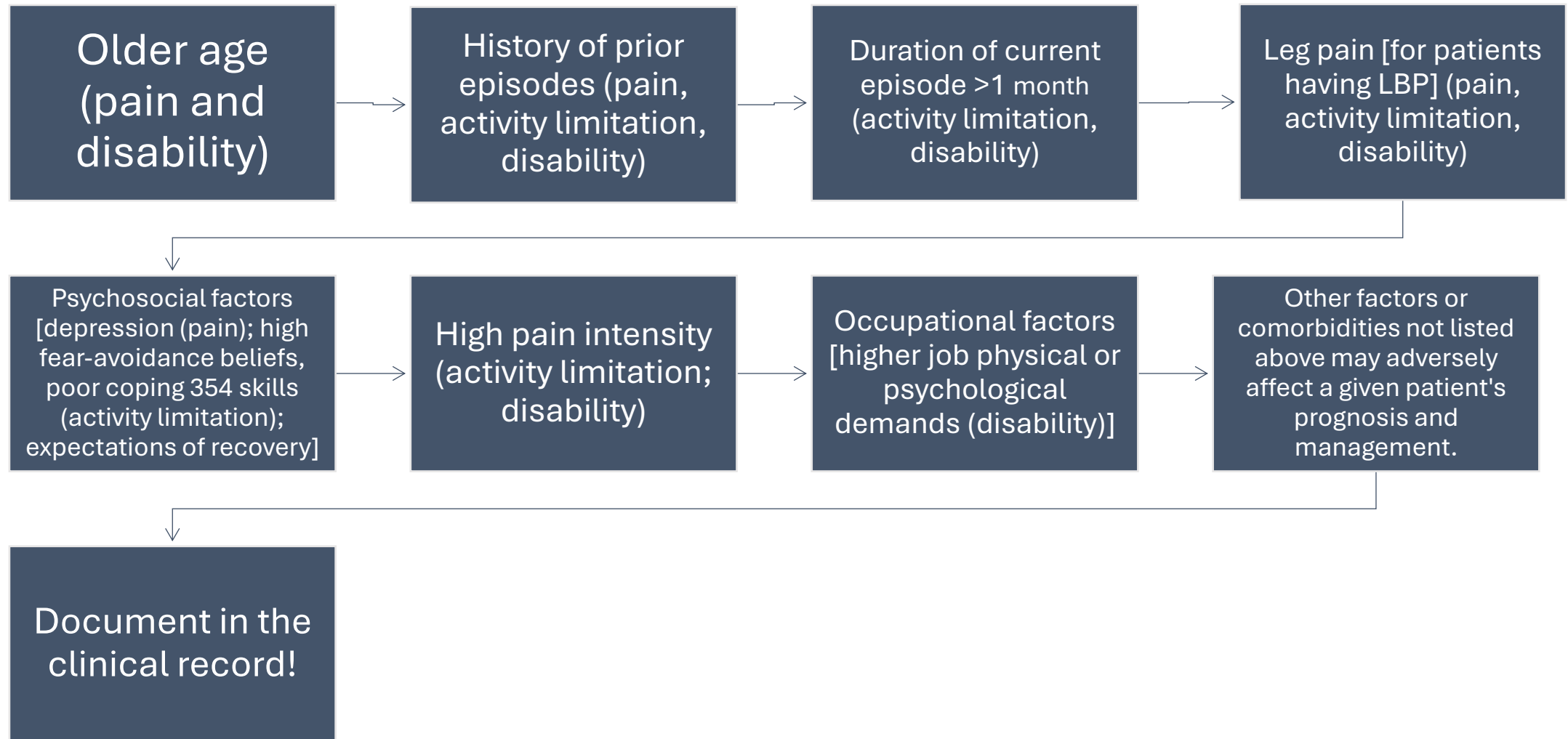
Unlike routine maintenance, supportive care is often "**as-needed**" **in response to symptomatic decline and is appropriate when a trial of withdrawing care has failed.** Similar to maintenance care, it is generally not covered by traditional Medicare when it's supportive rather than corrective.

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

Maintenance /
Supportive Care
begins...

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:

Ongoing “scheduled” care for those chronic pain sufferers who have a predictable need for care prescribed at specific times validated through a trial of withdrawal that demonstrated **regression of their condition**.

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.

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?

Key clinical questions for care plan decision making...

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.

Final Evaluation (Six months or prior)

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 Plan (Purpose)

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.

**When should we use an
ABN?**

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.



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/nY5Pi8lwEMW_Sjx4lll_EDwGV9EVYcFLzUWmcVpnt01tGqt-e1tB8CS6t_k93pv3QEMC2mLNOUZ2FouGt3q8G6nlrN-fypWcr0ZSbb4mi4GaDOWPhG_Qrw3NB_49HrUCbZyNdImQ2Lwgac8GA901Gy2du_JJvrM_pUVD7ZSgK0u0Jyyaw2OIIt09rMK4mgLmJFwmzlGD8wFNZCMqCjUbarNve0VPIG7PGVOo2u2DsJ6uc9Ae46HHNnOQfNwPyT_7_Z9Or2tVuQHtpG6z/



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.



Typical explanation to the patient...

"Sally, since we have finished your treatment plan for this episode of care, from this time moving forward you will be responsible for payment of your future chiropractic adjustments since they will be regarded as maintenance care.

You will need to sign the ABN form to demonstrate to Medicare that we've explained your future care is maintenance therapy and that you understand maintenance therapy will be your financial responsibility. If you reinjure yourself, Medicare may cover your treatment again but you must have a mechanism of injury and you must follow a treatment plan."



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



Questions or Comments

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