

Record Keeping and Self-Auditing

Preparing for a CMS Audit

Agenda

- Medicare Audit Overview
- Common Audit Findings
- Conducting a Mock Medicare Audit
- Hands-On Audit Exercise

Why do we care?

- Medicare Chiropractic Audits are underway.
- CMS and the Office of the Inspector General (OIG) have identified through numerous audits of the chiropractic community that a large portion of claims have been paid inappropriately.

Why do we care?

- 2016 OIG Work Plan:

“We will review Medicare Part B payments for chiropractic services to determine whether such payments were claimed in accordance with Medicare requirements.”

- “*Medicare inappropriately paid \$178 million for chiropractic claims in 2006...*”

- -Daniel R. Levinson; Inspector General

Why do we care?

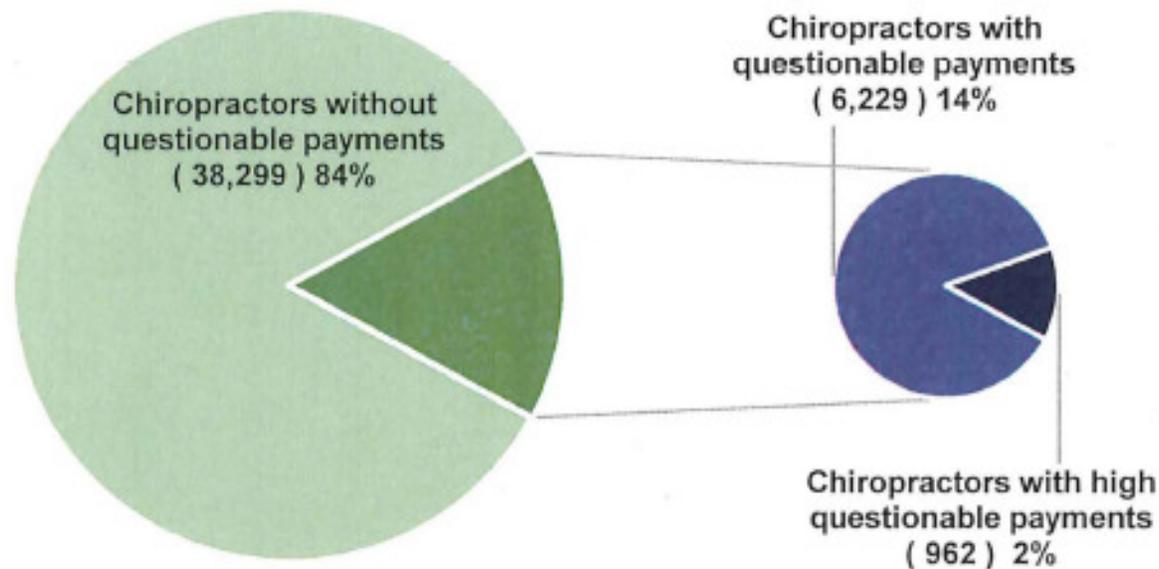
Amount of Projected Improper Payments and Rate of Improper Payments for Chiropractic Services, 2010–2014

Year	Amount of Projected Improper Payments for Chiropractic Services	Rate of Improper Payments for Chiropractic Services
2010	\$256,897,088	43.9%
2011	\$263,038,123	44.1%
2012	\$277,795,837	47.4%
2013	\$273,488,430	51.7%
2014	\$303,816,558	54.1%

Source: CMS, *Supplementary Appendices for the Medicare Fee-for-Service Improper Payments Reports* for 2010–2014.

Why do we care?

Number and Percentage of Chiropractors With and Without Questionable Payments in 2013



* A total of 45,490 chiropractors were paid by Medicare in 2013. The total number of chiropractors with questionable payments in 2013 was 7,191.

Medicare Audit Overview and Consequences

- Medicare Audits are designed to detect and correct past, improper Medicare Payments.
- Consequences of Noncompliance:
 - Recoupment/Penalties
 - Patient Record Errors
 - Potential (probable!) noncompliance with other payer requirements
 - Medicaid
 - Commercial insurers

Medicare Covered Treatment

➤ Necessity for Treatment:

- Acute Spine Subluxation (AT modifier):
 - Treating for a new injury, identified by x-ray or physical examination
 - Expected improvement in, or arrest in progression, of the patient's condition
 - Acute flare up of a chronic condition

Medicare Non-Covered Services

➤ Maintenance Therapy:

- Services seek to prevent disease, promote health, or prolong/enhance quality of life.
- Maintain or prevent deterioration of a chronic condition.
- No further clinical improvement can be reasonably expected from continuous ongoing care.
- Treatment is supportive rather than corrective in nature.

Medicare Non-Covered Services

- Financial Disclosure Form found on ChiroConnect
 - Mandatory Submission Guidelines



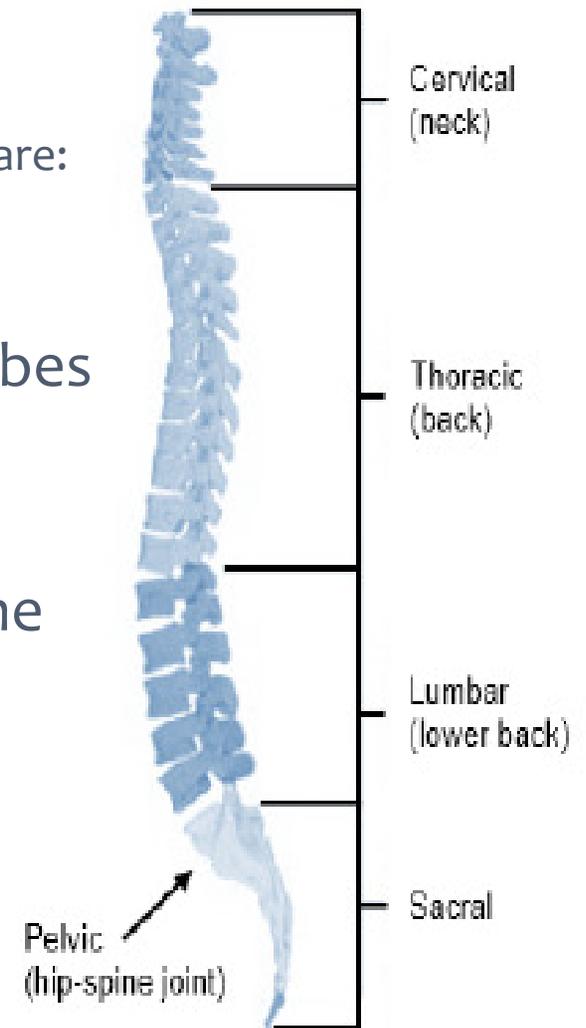
Medicare
Financial Disclosure



Commercial/
Medicaid Financial Disclosure

Key Billing Requirements

- Primary diagnosis of subluxation. (For Medicare: M99.01 – M99.05)
- The appropriate CPT code that best describes the service (98940, 98941, 98942 and S8990)
- The appropriate modifier that describes the services. (- AT)



What's missing?

Some of the most common errors identified in these audits include:

- Missing date of service in the patient records.
- Missing signature of the ***treating*** provider.
- No/Insufficient documentation of all spinal levels being treated.
- No/Insufficient documentation that all services were medically necessary.
- No/Insufficient treatment plan.
- Patient name is not on every page.

Common Audit Findings

➤ Technical Errors

- Records not being submitted when requested
- Missing Signatures
- Dates of Service not included in the record
- Other required elements are missing from the record

Source: Medicare Learning Network, "Overview of Medicare Policy Regarding Chiropractic Services"



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Signatures

- Handwritten or electronic signatures are acceptable
- Signatures should be semi-legible or a signature log should be available to Medicare contractors.
 - Include a legible list of provider's name, initials and sample of signature
- In place of a signature log, a Signature Attestation Statement can be provided.
 - This attestations can only be submitted by the author of the record(s) in question.

Common Audit Findings

- Documentation does not substantiate that all billed procedures were performed.
- Examples:
 - No documentation or insufficient documentation that all spinal levels of manipulation billed had been performed
 - No documentation that each manipulation reported related to a relevant symptomatic spinal level

Source: Medicare Learning Network, “Overview of Medicare Policy Regarding Chiropractic Services”

Common Audit Findings

- Insufficient or absent documentation that all procedures or services performed were medically necessary.
- Examples:
 - Required elements of history and examination were absent
 - Treatment plan absent or insufficient

Common Audit Findings

- Treatment billed was not a Medicare covered service.
- Examples:
 - Treatment provided was “maintenance therapy,” which is not covered by Medicare.
 - Manual Devices
 - Diagnostic Services

How can these issues be avoided?

- Maintain well-constructed treatment plans with clear and measurable goals.
- Internal detection is the best way to prevent findings of non-compliance.
- Conduct routine self audits.

What is self auditing?

➤ CMS defines self auditing as:

“A self-audit is an audit, examination, review, or other inspection performed both by and within a given health care practice or business. Self-audits generally focus on assessing, correcting, and maintaining controls to promote compliance with applicable laws, rules, and regulations.”

Conducting a Self Audit

- Proactively monitor your own practices.
- Implement new processes to avoid identified mistakes.
- Monitor new processes to ensure the 'fix' is working.

Medicare Documentation Requirements

- Documentation Must Be Placed in Patient's File
- Initial Visit
 - History
 - Description of the present illness
 - Evaluation of musculoskeletal/nervous system through physical examination
 - Diagnosis
 - Treatment Plan with measurable goals
 - Date of Initial Treatment
 - Patient's medical record
- Subsequent Visits
 - History
 - Physical Examination
 - Documentation of treatment given on day of visit

Documentation Self Audit

- Example: Billing for code 98941 (spinal, 3-4 body regions)
 - Does the note support this code?
 - Does it the note meet all of the areas required by CMS?

Billing Self Audit

- Example: Billing for initial evaluations (codes 99201-99203)
 - Were all new patients billed for an initial evaluation?
 - Are all patients being billed at the same level?
 - Does the billing code level match your documentation?

Self Auditing Tools

- Utilize the resources available on ChiroCare Connect
 - Sign into ChiroCare Connect
 - Go to Toolkit
 - Scroll down to Medicare Audit
- Additional information is available on www.ChiroCare.com

Preparing for a Medicare Audit

Medicare Audit Tools



General Patient
Chart Audit

Preparing for a Medicare Audit

Self-Audit Tracking Log



Self-Audit
Tracking Log

Self Auditing Frequency

- There are no specific guidelines to follow.
- The General Patient Chart Audit form recommends:
“ten active patient charts with at least 3-5 prior visits - the most recent visit should have taken place within the past 6-12 months”
- Starting out, self audits should be conducted regularly and eventually when no errors are found, the self audits can become less frequent.

CMS Self Auditing Tools

- <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/audit-selfaudit-factsheet.pdf>
- www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/audit-selfaudit-booklet.pdf?linkId=22844864

Preparing for a Medicare Audit

Hands-On Auditing Exercise

Questions?

Thank you!

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