Top 10 Mistakes
Chiropractors Make

John Davila, D.C., FICC

Custom ChiroSolutions

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Disclaimer: Website references are included at the end of each chapter. At the time of publication these website links were validated as active.

Letter from the Author

As I started this project, I knew I would get praise from some and scorn from those who make their money from the practice management and insurance regulator worlds. However, I know the best way to deflect any criticism is to keep my opinions on the subject to a minimum and let the facts speak for themselves. With that in mind, I've put together the 10 most common misconceptions chiropractors hear from practice management consultants and dispelled them with fact.

Chiropractic consultant advice on marketing techniques and billing procedures is something I've collected from personal experience and from clients for whom I've consulted within the past few years. I began to create a list of questions and answers, or FAQs, to address the most frequent inaccuracies with truth and supporting evidence to provide doctors with real answers and force consultants to provide compliant, beneficial advice. Having said that, I am neither in favor of nor opposed to the use of practice management companies. My personal agenda is to stop hard-working people in this profession from becoming easy prey or "low-hanging fruit" for insurance companies to profit from. This can only be done by getting the unbiased truth into the hands of a profession that desperately needs it.

John D. Davila, D.C., FICC

Mistake One

Medicare and insurance companies will never go after chiropractors.

This is one of my favorite lines I personally heard in 2000, told to me by a prominent practice management guru. His information on new-patient marketing produced phenomenal results in my practice, but when I brought an OIG (Office of Inspector General) advisory opinion to this consultant I was told, "Medicare will never go after chiropractors because we don't make enough to make it worth it."

With that, I resigned from this management company and started to apply the rules as they were set forth by the Federal government in the Department of Health and Human Services, Office of Inspector General's "OIG - Compliance Program for Individual and Small Group Physician Practices."

This document, listed in the Federal Register, states "as it relates to improper inducements, kickbacks and self-referrals, a physician practice would be well-advised to have standards and procedures that encourage compliance with the anti-kickback statute ... Remuneration for referrals is illegal because it can distort medical decision-making, cause overutilization of services or supplies, increase costs to Federal health care ..."

If you think back to 2000, did you know anyone who had been audited? Probably not, but I do. I had been asked for money back from Blue Cross Blue Shield of South Carolina. Although I was 100 percent successful in my own defense, I needed to find a way to protect my practice due to the costs incurred to defend myself AFTER THE FACT!

Compare this statement 10 years later; it's in the news every day and talk of this activity runs rampant through the halls of Congress. But, why go after chiropractors? Aren't we small potatoes? Well, the answer is "yes" and "no." From a dollar-spent standpoint we aren't anything to be worried about, but when the OIG puts our profession on their radar and completes their own investigation revealing a scathing amount of money has been "improperly paid" to chiropractors, it gets attention. When the OIG's reviews were released in 2005 and 2009, U.S. senators and members of Congress who support our cause ran for cover because the OIG reported 40 percent of what we bill was to be considered maintenance care.

Due to these findings, we are targets because of the percentage of errors and not the dollar amount spent. So, are they going to come after chiropractors? Yes, and they are going to keep coming.

Reference:

OIG: Inappropriate Medicare Payments for Chiropractic Services

Mistake Two

I can charge a Medicare patient a yearly fee, have them pay up front for the entire year, and discount the patient's deductible and co-payments.

Over the years, one of the most common and veteran practice management mainstays has been to get patients to pre-pay for an entire year of care. Early in my chiropractic career, I sat in courses where this was taught and totally believed all the talk about how patients will "follow their money" and return for visits they purchased. Considering the possible penalties for violating CMS (Centers for Medicare & Medicaid Services) policy, not once did anyone ever cover the steps on how to deal with a Medicare patient.

In an Office of Inspector General release on "Overcharging Beneficiaries," the OIG alleged the physician created a program whereby the physician's patients were asked to sign a yearly contract and pay a yearly fee for services that the physician characterized as "not covered" by Medicare. The OIG further alleged that because at least some of the services described in the contract were actually covered and reimbursable by Medicare, each contract presented to the Medicare patients constituted a request for payment other than the co-insurance and applicable deductible for covered services, and was in violation of the terms of the physician's assignment agreement. In addition to payment of the settlement amount, the physician agreed not to request similar payments from beneficiaries in the future.

The issue is even further clouded by consultants who advocate steps to discount the patient's liability or amount due for their deductible and co-payment without regard to common network participation agreements the doctor may have with insurance companies. Second to medical necessity language in an insurance contract is the requirement that the provider attempt to collect all charges from the insured. If this does not happen, it can be considered an inducement in Medicare and violation of the doctor's contract with a private carrier.

A 1991 Federal Court ruled in favor of Cigna as it attempted to enforce a chiropractor to collect co- payments. Federal Circuit Court Judge Easterbrook stated:

"Co-payments sensitize employees to the costs of health care, leading them not only to use less but also to seek out providers with lower fees. The combination of less use and lower charges (together with the 20% reduction in insured payments in the event care is furnished) makes medical insurance less expensive and enables employers to furnish broader coverage (or to pay higher wages coupled with the same level of coverage)."

In this case, Cigna was allowed to NOT pay the chiropractor for his services because he did not attempt to collect the patient's co-payment.

References:

OIG Alert: Extra Contractual Charges Beyond Medicare's Deductible, Co-Insurance - A Potential Assignment Violation

Kennedy v Connecticut General Life Insurance Company

Mistake Three

You can opt out of Medicare.

When I'm on campus teaching students at numerous colleges, the number one issue that floors me is when a student plainly tells me they can opt out of Medicare and their consultant told them this. Why does this floor me? The answer is simply not only is it false, but it's also an expensive lesson to learn if confronted by Federal investigators. With fines for each violation maxing out at $10,000 per, it makes no sense to play "chicken" with Medicare.

This excerpt comes directly from a Medical Learning Network® MLN Matters® publication: "Opting out of Medicare is not an option for Doctors of Chiropractic. Note that opting out and being non-participating are not the same things. Chiropractors may decide to be participating or non-participating with regard to Medicare, but they may not opt out."

For further discussions of the Medicare "opt out" provision, see the Medicare Benefits Policy Manual (Chapter 15, Section 40; Definition of Physician/Practitioner)

Reference:

MLN Matters: Addressing Misinformation Regarding Chiropractic Services and Medicare

Mistake Four

You can give away free or reduced cost services to patients.

The Anti-kickback Statute states an inducement, according to the Federal government, is the act of offering remuneration to Medicare or Medicaid beneficiaries where the person offering the remuneration knows or should know that the remuneration is likely to influence the beneficiary to order or receive items or services from a particular provider. The "should know" standard is met if a provider acts with deliberate ignorance or reckless disregard. No proof of specific intent is required. Here, "remuneration" means to compensate a patient by offering something of value to choose you as a provider over another provider.

The "inducement" element of the offense is met by any offer of valuable (i.e., not inexpensive) goods and services as part of a marketing or promotional activity, regardless of whether the marketing or promotional activity is active or passive. For example, even if a provider doesn't directly advertise or promote the availability of a benefit to beneficiaries, there may be indirect marketing or promotional efforts or informal channels of information dissemination, such as "word-of-mouth" promotion by practitioners or patient support groups. In addition, the OIG considers the provision of free goods or services to existing customers who have an ongoing relationship with a provider likely to influence those customers' future purchases.

It's important to note in Georgia, Massachusetts, New Jersey, North Carolina and Texas the state laws are more comprehensive than others. An example of this is in Florida, where the state law has been found to supersede the Federal anti-kickback statute.

Reference:

OIG: Offering Gifts and Other Inducements to Beneficiaries

Mistake Five

You can bill insurance every January to help a patient with their deductible.

In every corner of the chiropractic universe this practice commences annually when it's time for the deductible to be met. I know this is the advice of two different consultants, and this question has been raised in numerous seminars. But if you look more closely at medical necessity policy, there is no provision for insurance to be billed at the beginning of an insured's policy to apply charges that are not medically necessary to their deductible.

The interesting part about this issue is when the doctor is asked where this billing advice came from, they say they learned it from their consultant or that's how they've always done it. If you look at Blue Cross Blue Shield's national policy on "medically necessary service" however, it's quite clear on what is to be billed to the carrier.

"Medically necessary services": Services or supplies as provided by a physician or other healthcare provider to identify and treat a member's illness or injury, which, as determined by the payer, are consistent with the symptoms, diagnosis, and treatment of the member's condition; in accordance with the standards of good medical practice; not solely for the convenience of the member, member's family, physician, or other healthcare provider; and furnished in the least intensive type of medical care setting required by the member's condition.

References:

Medicare: Benefit Policy Manual - Chapter 15
Aetna: Policy on Chiropractic Services

Mistake Six

If you are non-par with Medicare, you will never get audited.

With the growing number of doctors getting reviewed by Medicare carriers across the country, this seemed to be a quick fix to the problem. Just become non-par and all your problems will go away. The Medicare patient pays you and then can fight to get reimbursed on their time. This assumes that once you get paid by the patient, you as the doctor are free and clear of the "system" and totally out of the loop on the post-payment issues that would plague participating doctors. This type of advice is not only incorrect, but also potentially dangerous to the future of the practice because it can initiate a post- payment action.

One of the new wrinkles in the Medicare process is the recent addition to the ADR (Additional Documentation Request) a doctor gets when notes are requested. This new ADR mandates the ABN (Advance Beneficiary Notice) be furnished with the notes when responding to the carrier. This necessitates notes to prove medical necessity and to guarantee the ABN was used properly. Therefore, even if you are non-par you would still have to send in the ABN form and corresponding notes to verify that everything was done correctly to help the patient be properly notified of their financial responsibility regarding the case in question.

This excerpt comes directly from a Medical Learning Network® MLN Matters® publication: "Any Medicare claim submitted can be audited/reviewed; the non-participating (non-par) or participating (par) status of the physician does not affect the possibility of this occurring. CMS audits/reviews are intended to protect Medicare trust funds and also to identify billing errors so providers and their billing staff can be alerted of errors and educated on how to avoid future errors. Correct coverage, reimbursement, and billing requirements are readily available to assist you in understanding Medicare requirements. This information is in Medicare manuals that are at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html on the CMS website. In addition, an excellent way to stay informed about changes to Medicare billing and coverage requirements is to monitor MLN Matters® articles, such as this one, which are available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html on the same site."

Reference:

MLN Matters: Addressing Misinformation Regarding Chiropractic Services and Medicare

Mistake Seven

If I have a cash practice, I don't have the same documentation requirements as those who take insurance.

The way chiropractors are sold on this falsehood by consultants is by the promise of quick and easy patient management and increased flow in the office by not having to take proper documentation because it's not required. Once again, this is not true based on two different sets of requirements. The first is based on the rules that govern your state practice regulations. An example is in a state like Colorado where their Rule 22 states, "the patient's health history, presenting complaint(s), progression of care, diagnosis, prognosis and treatment plan must be reflected in the record keeping and written reports of the patient file." This rule is the minimum required for documentation of a patient's case regardless of the type of reimbursement in the case presentation.

When it comes to Medicare, the rule becomes even more specific as it relates to a patient's documentation if you're treating them in an active-care scenario.

This excerpt comes directly from an MLN Matters® publication: "Chiropractic care has documentation requirements to show medical necessity. The participating status of the provider is irrelevant to the documentation requirements."

References:

MLN Matters: Addressing Misinformation Regarding Chiropractic Services and Medicare

State of Colorado: Board of Chiropractic Examiners Rules and Regulations

Mistake Eight

I can be non-par, collect cash from Medicare patients and I don't have to bill Medicare.

This is the cry I hear from students across the country who are sold a bill-of-goods by consultants who market their wares based on the anti-insurance rant of how bad Medicare is and how insurance is evil so chiropractors should just collect cash from insurance patients and not worry about the ramifications. The CMS website posts these rules, and fortunately they are easy to understand, yet the penalty is quite harsh if not followed. For a chiropractor it boils down to two points: an adjustment is a covered service and chiropractors are not allowed to opt out of Medicare.

These two issues are addressed within one post located on the CMS website in the FAQs section under "What are the mandatory claim submission rules?" It states, "When a physician or supplier furnishes a service that is covered by Medicare, then it is subject to the mandatory claim submission provisions of section 1848(g)(4) of the Social Security Act (the Act). Therefore, if a physician or supplier charges or attempts to charge a beneficiary any remuneration for a service that is covered by Medicare, then the physician or supplier must submit a claim to Medicare. In order to receive payment for Medicare covered items or services from either Medicare (in the case of an assigned claim) or a Medicare beneficiary (in the case of an unassigned claim), a provider or supplier must be enrolled in the Medicare program. See the Code of Federal Regulations (CFR) title 42, part 424, section 505 (42 C.F.R. 424.505)."

If we dissect this answer we can see if a Medicare patient is given an adjustment, because it is a covered service we must send the bill to Medicare for the patient (chiropractors are not allowed to give the Medicare patient a superbill). When we add this to the fact that we need to be enrolled in Medicare in the first place in order to bill Medicare for the patient, we can extrapolate if we aren't enrolled we can't even treat the Medicare patient.

This excerpt comes directly from an MLN Matters® publication: "Being non-par does not mean you don't have to bill Medicare. All Medicare covered services must be billed to Medicare, or the provider could face penalties."

References:

MLN Matters: Addressing Misinformation Regarding Chiropractic Services and Medicare

CMS: Mandatory Claim Submission Rules

Mistake Nine

I can provide unlimited care for a fixed fee.

In a word the answer here is "maybe," and this is totally based on the state you practice in and its state insurance rules. The problem with this type of financial arrangement, which has become popular over the past few years with uninformed consultants, is it can possibly violate state insurance rules. This happens because the doctor has given the patient a monthly fee for any number of visits the patient desires. This type of care plan violates state insurance rules because it can be viewed as offering "insurance" to the patient to indemnify the patient against a future injury or loss. In other words, the doctor has assumed risk associated with the agreement made with the patient, similar to agreements insurance companies make with insured clients. In order to do this legally, most states require an entity that wants to indemnify another party against a loss be registered as an insurance company, and that can cost tens if not hundreds of thousands of dollars.

An example of where this type of practice arrangement is discouraged is in New York. The New York statute states: "The Practice's offer to provide unlimited services for a pre-paid fee is a reserved parameter, under New York Insurance Law s. 1101(a), for an insurance business that is appropriately licensed by the State of New York. For a Practice that is not licensed as an insurer, and which charges a flat fee as payment for unlimited services over a set period of time is in violation of N.Y. Ins. Law s. 1102. Insurance Department, Opinions of General Counsel, Opinion Number 00-12-14."

Reference:

Contracts for the Provision of Unlimited Chiropractic Services to Patients

Mistake Ten

I went to a seminar and the manufacturer told me that I could bill neuromuscular re-education or gait training for the use of taping, strapping or orthotics training.

Neuromuscular re-education and gait training cannot be billed for services rendered to a chiropractic patient with symptoms that are routinely handled in a chiropractor's office. While both are time-based (in 15-minute units) and require direct one-on-one contact by the provider, they are not appropriate for most musculoskeletal rehabilitation scenarios because the insurance carriers have also put the additional requirement that the patient have an upper motor neuron lesion, stroke or internal head injury to qualify for coverage.

Although the patient can perform an exercise on a wobble board for balance, the question is, "Does the patient's condition rise to the level required by the carrier for the third party to pay you for it?" In most cases, even though the chiropractor CAN perform the service, the usual patient seen in a chiropractor's office does not have the condition that the carrier requires they have to qualify for reimbursement. The long-term issue with this type of billing advice is that the insurance companies know the diagnosis (the doctor provided it on the submitted claim form) of the patient and they know the chances of a stroke patient being in a chiropractor's office is usually slim. When they add together these points, it becomes easy to decide who to audit because the odds are in their favor that the practice will lose a post-payment audit.

I understand there are chiropractic-specific coding manuals and national associations that claim you can bill the service, and technically they are correct. You could bill the service to the patient. But the issue at hand is, "What is the insurance carrier's policy?"

References:

Aetna: Policy on Physical Therapy Services

Aetna: Policy on Cold Laser and High-Power Laser Therapies

Final Thoughts

It's been my experience there are three separate and distinct responses from doctors who come across information that dispels the things they thought were tried and tested to be true. The first two really don't need help getting compliant because they will either A) tidy up the few things in their office that need fixing by themselves, or B) deny everything in this article while saying to themselves and everyone else around them, "I don't care! I'll just wait for the cops to come take me away."

But the group of doctors I'm most worried about is also the most vulnerable. These are the doctors who know there are problems and want nothing more than to do the right thing. Their main issue is feeling overwhelmed by the task at hand. They just don't know where to begin to clean it all up.

When I was in practice I made all of these mistakes for a time. But after researching these practice management tips, and taking time to understand the difference between what I was being taught and what the rules were, I found this huge gap between the two that needed to be bridged.

In the end, there is hope. There is a middle ground between "rules" and "practice" where you can still be the doctor, run your business, and manage the patient while keeping the insurance companies off your back. What I've found is chiropractic school prepared us to be good doctors and care for patients, while practice management groups provided us with tactics to reach more people and the management of those patients. There has never been a program to prepare you for when your practice collides with the requirements of being in business ... until now.

At Custom ChiroSolutions, we have the expertise and resources to help any practice navigate the rules and regulations of the insurance industry, become compliant and, in the end, see your practice become more successful.

For more information visit: www.customchirosolutions.com

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Self-Assessment

1. Are your notes "pain-based"?
   Yes ❑ *No* ❑
2. Do you include questions about how a patient's "activities of daily living" are improving in your daily notes?
   Yes ❑ *No* ❑
3. Do you use the same adjustment code for billing?
   Yes ❑ *No* ❑
4. Do you include an outcomes assessment tool score with a goal score in your documentation?
   Yes ❑ *No* ❑
5. Do you code adjustments in active care the same as in wellness care?
   Yes ❑ *No* ❑
6. Does your documentation match your philosophy and the way you practice?
   Yes ❑ *No* ❑
7. Do you offer free services to your patients?
   Yes ❑ *No* ❑
8. Do you give discounts to your patients?
   Yes ❑ *No* ❑
9. Do you have a compliance manual?
   Yes ❑ *No* ❑
10. Do you perform internal audits of your documentation and billing every 90 days?
    Yes ❑ *No* ❑
11. Did you update your notes to match the new documentation requirements for ICD-10?
    Yes ❑ *No* ❑
12. Do you bill Medicare directly?
    Yes ❑ *No* ❑

Fax this page to 800-974-3479 and we'll contact you to schedule a complimentary 30-minute practice and compliance assessment.

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