Chiropractic Coding & Compliance Alert

Compliance: Be Forewarned With Palmetto's First Quarter Review of Claims Denials

Safeguard your practice with these 4 Medicare tips.

Denials are a given for medical practices, but a recent review by CMS carrier Palmetto GBA tallied shocking numbers: almost 66 percent of claims reporting either of the two most common services i.e. 98940 (Chiropractic manipulative treatment [CMT]; spinal, 1-2 regions) or 98941 (... spinal, 3 to 4 regions), or both; had to be denied for multiple reasons. The carrier reviewed 19,940 chiropractic service claims submitted between January and March 2015. After analysis, only 6,835 claims could be allowed and the remaining 13,105 were denied.

What is it with chiropractic codes that the denial rates are so persistently high? "The diagnosis codes don't warrant the level of the procedure code chosen or a modifier is missing," believes **Doreen Boivin, CPC, CCA,** with Chiro Practice, Inc., in Saco, Maine.

Good news: Medicare tells you about the most common trivial mistakes they found the providers committed. Read on to learn how you can avoid being grouped with the denials.

1. Provide Prompt Response to ADRs

As a part of the medical review process, claims are randomly selected for ADRs, or additional documentation requests. Providers should respond to the request within 30 days. If they don't, the claim is automatically denied on the forty-fifth day. Around 68,000 (or more than half) of the denied claims were for this reason alone! This is the scenario even though "most respond within the 30 days," according to Boivin.

Remember: Medicare contractors are authorized to collect medical documentation by the Social Security Act Section 1833(e), which states, "No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period."

2. Go the Extra Mile in Documentation

Around 6, 200 claims were rejected on grounds of insufficient documentation. The gaps included missing patient history, inadequate treatment plans, incomplete P.A.R.T. exam to document subluxation, and poor handwriting, amongst others.

"Take time with patients and then give time to do the documentation," advises Boivin. "Top it up with training on getting the documentation correct."

Palmetto identified missing or insufficient documentation regarding:

- Required elements of the history and examination
- Treatment plans lacked specific goals with objective measures to evaluate treatment effectiveness
- P.A.R.T. exam to document subluxation. The elements of a P.A.R.T. exam stand for Pain, Asymmetry, Range of Motion, and Tissue/Tone. To evidence subluxation, two of the four elements must be present, one of which must be asymmetry or range of motion abnormality.
- Documentation of the treatment given on the day of visit.
- Documentation submitted is not legible, with use of abbreviations.

- Subluxation for each spinal level manipulated.
- Whether each manipulation performed related to a relevant symptomatic spinal level identified in the P.A.R.T. exam
- Whether all spinal levels of manipulation billed on the claim had actually been performed.

To wade through this list, Palmetto GBA gives you a checklist to assist when you respond to a request for medical records, and also gives clean sweep documentation for the next patient you see.

Go to the Palmetto GBA website to learn more. Under 'Medical Review,' click on 'Chiropractic Services Checklist.'

3. Pen Down Those Impeccable Signatures

It's a pity that 70 claims were denied just because of improper signatures. Here are a few facts that Palmetto tells you to be wary of:

- Medicare requires the service to be authenticated by the provider.
- The signatures should carry the providers first and last name, legible.
- Double check the documentation carries a signature attestation or a signature log.

You would agree that here, just being a little more careful is all that is required, to circumvent a denial you definitely do not deserve. "Just do it right the first time," writes off Boivin.

4. Check Out Palmetto's Tips for Medical Necessity

According to Palmetto, complete documentation is a prerequisite to create a clear picture of the patient's illness and treatment. It should tell the reader of the patient's baseline condition, prescribed treatment, treatment timelines, and how the patient responds functionally. Remember to use objective and measurable parameters in your documentation.

Objective goal setting: While setting goals, remember to include restoration or measurable improvement in the impaired activities of daily living that the patient may be experiencing due to pain and the diagnosed problem.

Example: Suppose a patient complains that he is in so much pain that he cannot stand more than 20 minutes. His pain on the Visual Analogue Scale (VAS) is 9. After your assessment, you decide to set your goal as decreasing the pain VAS level to 3. Going further, you should also consider a goal to improve the patient's standing capacity realistically, such as to one hour.

No judgments please: Remember to document measurable improvement towards your goals on subsequent visits, and not a judgmental "patient is getting better."

Don't slack on follow ups: Though you do not need this detailed an assessment on the subsequent visits, remember to document the progression of treatment in terms of periodic reevaluations at regular intervals. In case of an ADR request, you must invariably include initial and updated evaluations.

The road ahead: The Palmetto GBA expects to continue keeping a close watch by conducting service-specific prepayment review in the next quarter. This review will identify, substantiate, or disprove questionable billing patterns.

Arm yourself: Follow the ACA documentation guidelines. Take the time now to get it right so in the future you don't have to fight for getting paid. "Train your staff to help you with reviewing," adds Boivin, so that billing can be done correctly and clean the first time.