
ChiroArmor
Compliance
Re-Imagined
Steven Conway DC, Esq.

SIMPLE PROCESS

- Provide information to patient
- Ascertain ability to understand and agree to information
- Obtain consent
- Document in notes
- Have patient sign a form
- Start treatment only after receiving correct informed consent.

WHY ARE THE MAJORITY OF CHIROPRACTORS NOT DOING IT?????
WHAT ARE YOUR CURRENT OFFICE PROCEDURES?

- **Form only included with new patient intake folders (basically stays in folder after patient signs in the waiting room)**
- **Specific form that is completed after a full discussion and explanation with the patient**
- **Forms in each treatment room for necessary updates**
- **Do you adjust on the first visit?**

ISSUES WITH THE INTAKE FORM SYSTEM

- **Do you really have a valid informed consent?**
  - **Did you complete the required 6 elements of an informed consent?**
    - **Was the patient correctly informed?**
    - **Did the patient fully consent?**
  - **Will it hold up in court?**

WHAT ARE YOUR CURRENT OFFICE PROCEDURES?

- **What oral process is combined with your paper or digital documentation?**
  - **Report of findings?**
  - **What elements or information do you currently discuss with the patient to obtain the necessary consent for examination and treatment**
- **New Patient**
- **Returning established patient**
- **Exacerbations**
- **New injuries**
- **Delegation issues**

SUMMARY

- **Only relying on intake form is not valid**
- **Adjusting on first visit requires a proper informed consent process prior to actual treatment**
- **Informed consent is not a macro…. It needs to be individualized to every single patient.**

INFORMED CONSENT

- When do you need to ask for consent?
  - Consultation
  - Examination
    - Ortho/ Neuro tests? (every tests?)
    - X-ray?
    - Invasive diagnostics
  - Before treatment
    - Same day treatment procedures
  - One and done?

INFORMED CONSENT STANDARDS

- **Increase in MP claims being won not on breach of standard of care, but for improper informed consent.**
  - **Review the different Informed consent standards**
    - **Reasonable Physician Standard**
    - **Reasonable Patient Standard**
    - **Reasonable Chiropractic Standard (Wisconsin only state)**

REASONABLE PATIENT STANDARD

- Whether a reasonable patient would have considered the information sufficient to make an informed decision.
- The problem with Dr. Google.

REASONABLE PHYSICIAN STANDARD

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

REASONABLE CHIROPRACTIC STANDARD

- Only in Wisconsin!
- Based on what a reasonable chiropractor would disclose
  - MD's can't testify against us

REASONABLE CHIROPRACTIC STANDARD

- **446.08 Informed consent.** Any chiropractor who treats a patient shall inform the patient about the availability of reasonable alternate modes of treatment and about the benefits and risks of these treatments. The reasonable chiropractor standard is the standard for informing a patient under this section. **The reasonable chiropractor standard requires disclosure only of information that a reasonable chiropractor would know and disclose under the circumstances.** The chiropractor's duty to inform the patient under this section does not require disclosure of any of the following:

(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.

6 ELEMENTS OF A PROPER INFORMED CONSENT

• Decision making capacity

- A clinical determination made by the practitioner that a patient has the requisite capacities to make a medical decision. (This is not the same as "competency" which is determined by the court.
  - Four major components:
    - Understanding
    - Appreciating
    - Formulating
    - Communicating
  - The first 2 components represent the patient's ability to understand and appreciate the nature and expected consequences of each health care decision. This includes understanding the known benefits and risks of the recommended treatment options, as well as any reasonable alternative options including no treatment.
  - The later 2 represent the ability to formulate a judgement and communicate a clear decision concerning health care

6 ELEMENTS OF A PROPER INFORMED CONSENT

- For the patient's consent to be valid, the DC needs to review the following six elements
  - The patient's diagnosis/condition and the proposed treatment, modality or procedures for correction.
  - The relevant risks and benefits of the proposed treatment, modality or procedures
  - Alternative treatment or procedures that are available to the patient and the relative risk, benefits, and uncertainties related to each alternative;
  - The risk and benefits of not receiving or undergoing any treatment procedure
  - The assessment of the patients understanding of the information provided (decision making capacity)
  - The acceptance by the patient to undergo the recommended treatment, modality or procedure.

6 ELEMENTS OF A PROPER INFORMED CONSENT

- Element #1
  - The patient's diagnosis/condition and the proposed treatment, modality or procedures for correction.
  - Basically a report of findings type communication with the patient signing a final document with the personal information included.

6 ELEMENTS OF A PROPER INFORMED CONSENT

- Element #2
- The relevant risks and benefits of the proposed treatment, modality or procedures
- Risk:
  - the possible undesirable outcomes of a treatment or procedure, including known side effects, complications, serious social or psychological harms or other adverse outcomes.
  - Discussion of Stroke on every case
  - Full spine adjusters / Full spine examiners?

6 ELEMENTS OF A PROPER INFORMED CONSENT

- Element #3
- Alternative treatment or procedures that are available to the patient and the relative risk, benefits, and uncertainties related to each alternative;

6 ELEMENTS OF A PROPER INFORMED CONSENT

- Element #4
- The risk and benefits of not receiving or undergoing any treatment procedure

6 ELEMENTS OF A PROPER INFORMED CONSENT

- Element #5
- The assessment of the patients understanding of the information provided (decision making capacity)

6 ELEMENTS OF A PROPER INFORMED CONSENT

- Element #6
- The acceptance by the patient to undergo the recommended treatment, modality or procedure.

6 ELEMENTS OF A PROPER INFORMED CONSENT

- Recommended Minimal documentation:
- “discussed findings with patient including.....”
- “discussed my recommendations for care including....”
- “discussed the following risks and benefits including alternate treatment.....”
- “the patient appeared to understand and agreed to proceed with my recommended treatment plan.”

6 ELEMENTS OF A PROPER INFORMED CONSENT

- Document the patient encounter when obtaining informed consent in your notes.
- Patient initials for each element
- Patient sign informed consent document
- Review for future material changes in the case and if a new informed consent is necessary.

PRACTICAL APPLICATION

- Create a form that includes all 6 elements
- Macro parts of the form, but also individualize for each patient
- Have the patient initial after you complete each element
- Not a one and done.
  - Consistently review for new potential requirements that would necessitate a new informed consent.
  - Error on side of doing a new form when in doubt.

SUMMARY

- Do not rely solely on the signed intake document.
- Appraise the patient's ability to receive and understand the information
- Provide the 6 elements
- Have the patient initial next to the elements and sign the final form
- Review for material changes that would necessitate a new informed consent from the patient.
- A proper informed consent not only protects you should a claim arise, but it creates greater trust with the patient as they are fully informed.

DOCUMENTATION COMPLIANCE CASE #1

- **Exclusion from Medicare**

Medicare Compliance

- Case #1: chiropractor midwest office receives a letter from Medicare
- Small Midwest town. Has a single CA working in the front office.
- No Audit of records.
- Receives a letter from WPS:
  - Excluded from Medicare for 3 years and request for all $ for past 3 years.

Medicare Compliance

- Case #2: chiropractor east coast office receives a letter from Medicare
- Excluded from Medicare for 3 years and request for all $ for past 3 years.
- Exclusion related to billing company
  - Hired an ex-Insurance CA who had started her own business for chiropractic offices to process your insurance claims.

Medicare Compliance

- Compliance fail point related to internal medicare procedures.
  - Medicare requires all participants to monitor vendors associated with the office that are related to control or management functions for excluded status.
  - DC in case #2 did not even know that she had to do this, which does not matter to CMS.

Medicare Compliance

- OIG Exclusion Website
  - https://exclusions.oig.hhs.gov
- Search for:
  - All new employees before hiring
  - All existing employees monthly
  - All Business Associates before hiring and quarterly

Medicare Compliance

- OIG Exclusion Website
  - https://exclusions.oig.hhs.gov
- Searching issues
  - Name has to be correct and try other alternatives such as nick names
  - 30 day window to report if you find a hit
  - Only allows for first and last name
  - “Should have known” is your responsibility.

DOCUMENTATION COMPLIANCE CASE #3

- **DOJ investigation related to inducement**

Medicare Compliance

- Case #3 U.S. Department of Justice vs chiropractor

- **I. M. Friendly, D.C., from nice town**, Iowa, and his clinic, **Friendly** Chiropractic, P.C., have agreed to pay $79,919 to resolve allegations Friendly **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 Dr. Friendly**. 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.

Medicare Compliance

- U.S. Department of Justice vs Dr. Friendly
- Source of complaint was unknown
- Initial Allegations
  - **Inducement by providing free services** to Medicare patients
  - Included both AT and Maintenance care in the complaint
- Secondary allegations
  - Coded **all** maintenance patients with 98940

Medicare Compliance

- Inducement: Section 1128A(a)(5)
  - This section of the Act bars the offering of 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 providers.
  - The “should Know” standard is met if a provider acts with deliberate ignorance or reckless disregard.

Medicare Compliance

- Inducement: Section 1128A(a)(5)
  - The “inducement” element of the offense is met by an offer of valuable 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 does not directly advertise or promote the availability of a benefit to beneficiaries, there may be indirect marketing or promotional efforts of information channels of information dissemination such as “word of mouth” promotion by practitioners.**
  - In addition, the OIG considers the providing of free goods or services to exiting customers who have an ongoing relationship with a provider likely to influence those customers for future purchases.

Medicare Compliance

- Under section 1128(A)(a)(5) of the Social Security Act enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), **a person who offers or transfers to a Medicare or Medicaid beneficiary and remuneration that the person knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner** or supplier of Medicare or Medicaid payable items or services may be liable for civil money penalties (CMPs) of up to $10,000 for each wrongful act. For purposes of section 1128A(a)(5) of the Act, the statutes defines "remuneration" to include, without limitation, waivers of copayment and deductible amounts (or any part thereof) and **transfers of items or services for free or for other than fair market value.**

Medicare Compliance

- Points to consider
  - First, the OIG has interpreted the prohibition to permit Medicare or Medicaid providers to offer beneficiaries inexpensive gifts (other than cash or cash equivalents) or services without violating the statute. For enforcement purposes, inexpensive gifts or services are those that have a retail value of no more than **$10 individually, and no more than $50 in the aggregate.**

Medicare Compliance

- Points to consider
  - Second, providers may offer beneficiaries more expensive items or services that fit within on of the five statutory exceptions:
    - Waivers of cost sharing amounts based on financial need;
    - Properly disclosed copayment differentials in health plans;
    - Incentives to promote the delivery of certain preventive care services;
    - Any practice permitted under the federal anti-kickback statute
    - Waivers of hospital outpatient copayments in excess of the minimum copayment.

Medicare Compliance

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Medicare Compliance

- Compliance fail point related to internal Medicare procedures.
  - Offer or Provided free services to Medicare patients.
    - 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, gift cards or other type of advertising system for new patients.
  - Do not downcode or upcode services.

DOCUMENTATION COMPLIANCE CASE #4

- **Opt out of Medicare**

Medicare Compliance

- The false belief that chiropractors can **opt out** of Medicare-you can't
  - You are either in and following the rules or you are 100% out.
- Can not be "off the radar" and treat Medicare patients for cash
- Can not be a "maintenance" practice and force a patient to sign box 2 of the ABN to be a patient.
- Can not creatively code to have only non-covered services.

40.4 – Definition of Physician/Practitioner (Rev. 62, Issued: 12-22-06, Effective: 11-13-06, Implementation: 04-02-07) For purposes of this provision, the term "physician" is limited to doctors of medicine; doctors of osteopathy; doctors of dental surgery or of dental medicine; doctors of podiatric medicine; and doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the State in which such function or action is performed; no other physicians may opt out*. Also, for purposes of this provision, the term "practitioner" means any of the following to the extent that they are legally authorized to practice by the State and otherwise meet Medicare requirements: Physician assistant; Nurse practitioner; Clinical nurse specialist; Certified registered nurse anesthetist; Certified nurse midwife; Clinical psychologist; Clinical social worker; Registered dietitian; or Nutrition Professional. **The opt out law does not define "physician" to include chiropractors; therefore, they may not opt out of Medicare and provide services under private contract.***

OPT OUT SUMMARY

- Currently Chiropractors can not Opt Out of the Medicare system.
  - If you want to treat Medicare patients you need to be in the system and follow the rules.
- Can NOT:
  - Alter ABN and have sign on t he first visit for maintenance unless it is actually for maintenance.
  - Just have the patient pay cash and be off the radar
  - Not register for Medicare and just treat patients for “non-covered services.”
    - Manual therapy vs CMT
  - Not bill for CMT services.

DOCUMENTATION COMPLIANCE CASE #5

- **Cloning of documents**

Risk Management

- **Cloning**

Per the Centers for Medicare & Medicaid Services (CMS), “Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries” (Medicare B Update, third quarter 2006 (vol. 4, No. 3)). Per the Office of Inspector General (OIG):

RISK MANAGEMENT

- Copy-pasting, also known as cloning, allows users to select information from one source and replicate it in another location. When healthcare providers copy-paste information but fail to update it or ensure accuracy, inaccurate information may enter the patient's health records.
- Over-documentation is the practice of inserting false or irrelevant documentation to create the appearance of support for billing higher level services.
  - Some EHR technologies auto-populate fields when using templates built into the system.
  - Other systems generate extensive documentation on the basis of a single click of a checkbox, which if not appropriately edited by the provider, may be inaccurate. Such features can produce information suggesting the practitioner performed more comprehensive services than were actually rendered.
    - OIG 2013 workplan

RISK MANAGEMENT

- Potential cloning traps to avoid
  - Pulling previous history or examination data forward
    - Make sure you identify it as past information and not current. Use specific titles or headings to clarify.
  - Macros / check box
    - Make sure the wording does not box you in and compromise the visit.
      - Medicaid audit example related to daily note macro that is used on a first visit that talks about the “previous visit.”
  - Don’t clone the entire note.
    - Cloning entire note puts you in a difficult position for exact wording on each visit.
    - Already a problem with documenting differences from Monday-Wednesday to Friday.

Medicare Compliance

- Compliance fail point:
  - EHR cloning problems
    - Ability to bring data forward in most systems.
      - Bringing the initial examination information forward creates a misconception that the data was produced on that date.
        - Need for titles or headings to document the timing of the information such as initial history brought forward for reference.
    - Cloning is considered fraud by Medicare

Medicare Compliance

- Compliance fail point:
  - EHR cloning problems
    - Ability to bring data forward in most systems.
      - How do we handle daily notes to prevent cloning?
        - Symptom review
          - **Review of that specific date as compared to a system that asks:**
            - **Symptoms after last treatment**
            - **Symptoms in period between treatments**
            - **Symptoms associated today**

Medicare Compliance

- Compliance fail point:
  - EHR cloning problems
    - Ability to bring data forward in most systems.
      - How do we handle daily notes to prevent cloning?
        - Symptom review
          - **Use of VAS/NAS on each visit**
          - **Patient filling out the Symptom section of your notes to reflect their current position**
          - **Use of pictures with gradient scales**

Medicare Compliance

- Compliance fail point:
  - EHR cloning problems
    - Ability to bring data forward in most systems.
      - How do we handle daily notes to prevent cloning?
        - Objective review
          - **Review of goals from the treatment plan**
          - **Use of objective markers or goal post**
            - **Range of motion**
            - **Algometers**

Medicare Compliance

- Compliance fail point:
  - EHR cloning problems
    - Ability to bring data forward in most systems.
      - You need to provide a basic documentation of “changes since last visit” no mater how small they are.
      - Never simply clone your documents.

Medicare Compliance

- Compliance fail point:
  - The **opposite** of EHR cloning problems
    - Take extreme minimalist notes on date of service and then “magically” create new notes when a request for documentation is made by a carrier, audit or patient.
    - Abbreviations are OK if they are standardized.
      - Palmetto GBA example
    - The “travel card” issue

Contact information

- Steven Conway DC, Esq.
- ChiroArmor.com
- chirolaw@aol.com
- DrC@chiroarmor.com
- 888 892 9299
- 727 421 0407 personal cell