**CHIROPRACTIC SUMMIT ISSUES FIFTH MEDICARE BRIEFING**
**MEDICARE AUDITS PART II – WHAT THE CHIROPRACTOR NEEDS TO KNOW**

First convened in September 2007, the Chiropractic Summit represents leadership from some 40 organizations within the profession. The Summit meets regularly to collaborate, seek solutions, and support collective action to address challenges with the common goal of advancing chiropractic.

A major focus of the Summit is to improve practitioner participation, documentation, and compliance within the Medicare system. The article that follows below is the fifth in a series developed by the Chiropractic Summit Documentation Committee, and it focuses on Medicare audits.

Near the end of the last article it was indicated that Contractors must evaluate suspected claims errors through the use of "Probe" reviews. You may refer to that article for background and insight.

Under probe reviews, Contractors may initially examine 20–40 claims per provider for provider-specific problems. Contractors may also conduct widespread probe reviews (involving approximately 100 or more claims from multiple providers) when a larger problem, such as a spike in billing for a specific procedure, is identified. In either type of review, providers are notified that a probe review is being conducted and are asked to provide medical documentation for the claim(s) in question. Providers are then notified of the results of the probe review.

When probe reviews verify that an error exists, the Contractor classifies the severity of the problem as minor, moderate, or significant. Contractors may classify the severity of the error by determining the provider-specific error rate (number of claims paid in error), dollar amounts improperly paid, and/or past billing history. All levels of error will require that providers receive education on proper billing procedures and the collection of money from claims paid in error. Contractors will then respond to the billing problem(s) as appropriate for the level of severity, and determine what steps need to be taken to correct the problem(s).

Often, initial medical review (MR) is conducted by simply examining the claim itself, usually in an automated method. If more information is needed (a small percentage of cases), the Contractor will request access to medical records to confirm that the services rendered are reflected on the claim, coded correctly, and covered by Medicare.

Validating initial findings from MR evaluations may require additional reviews resulting in corrective action. To assist in MR evaluations, CMS designed MR Progressive Correction Action (PCA). PCA ensures that MR activity is targeted at identified problem areas and that imposed corrective actions are appropriate to the severity of the infraction of Medicare rules and regulations.

The following types of corrective actions can result from MR:

- **Education**—Problems detected at minor, moderate, or significant levels will require the Contractor to inform the provider of appropriate billing procedures.

- **Prepayment review**—Prepayment review involves MR of a claim prior to payment.
- **Postpayment review**—Postpayment review involves MR of a claim after payment has been made.

Providers with identified problems submitting correct claims may be placed on "prepayment review," in which a percentage of their claims are subjected to MR before payment can be authorized. Once providers have re-established the practice of billing correctly, they are removed from prepayment review.

Postpayment review is generally performed by using Statistically Valid Sampling. Sampling allows an underpayment or overpayment (if one exists) to be estimated without requesting all records on all claims from providers. This reduces the administrative burden for Medicare and costs for both Medicare and providers.

Both prepayment and postpayment reviews may require providers to submit medical records. When medical records are requested, the provider must submit them within the specified timeframe or the claim(s) will be denied as having no documentation. Provider feedback and education regarding MR findings is an essential part of all corrective actions. Feedback and education further ensure proper billing practices.

The purpose of the MR process is to make sure claims are paid correctly. DCs need to take certain measures to help meet this goal:

- Review and read all Contractor provider publications and be aware of Local Coverage Determination (LCD) coverage requirements and billing instructions.
- Make sure office staff and billing vendors are familiar with claim filing rules.
- Check records against billed claims.
- Perform mock record audits to ensure documentation reflects the requirements outlined in the LCD.
- Educate Medicare patients regarding any specific coverage limitations or medical necessity requirements for those services provided.
- The provider should keep in mind the following points:
    - Documentation must be provided, when requested, for every service selected for MR;
    - Documentation should demonstrate that the patient's condition warranted the type and amount of services provided;
    - Documentation must be legible, even if it is dictated or transcribed (be sure to include originals);
    - Daily notes must be signed; and
    - Each service must be coded correctly.

The provider has the right, following MR, to be educated on how to bill correctly and to have questions answered in a timely manner. The provider also has the right to appeal determinations, as long as the appeals are filed in accordance with regulations governing that process.

After claims have been reviewed, the provider will be notified of the result of the review (full denial, partial denial, or favorable/no denial). In the first two cases, full or partial denials, the contractor may decide to recoup the reimbursement from the provider (if the provider accepts assignment) or from the patient (if the provider does not accept assignment), with instructions to seek reimbursement from their provider. The provider must then reimburse the patient. It is at the time of receipt of these denials that the provider may choose to appeal.

The next article will summarize the appeals process. The reader is reminded that:

> *The Summit recommends and encourages all DCs to appeal improperly denied claims. We do not however recommend or encourage the frivolous appeal of claims. Appealing is not only a service to your patient, who has a right to have their payable covered services reimbursed, but also is a service to your profession.*

The members of the Summit Subcommittee on Documentation are Dr. Carl Cleveland III, Dr. Farrel Grossman, Dr. John Maltby, Dr. Peter Martin, Ms. Susan McClelland, Dr. Ritch Miller, Dr. Frank Nicchi, Mr. David O'Bryon and Dr. Frank Zolli. Dr. Miller served as principal author of this article with contributions from members of the subcommittee and documentation working group.

For further information on these subjects and others please refer to the sources for this article which include: CMS articles, publications and the CMS manual system, the ACA web site, www.acatoday.org/medicare and the ICA website, www.chiropractic.org.