Do You See What I See? How to Self-Audit Before Someone Else Does

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Director of Education
KMC University



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Please Note!

- The views and opinions expressed in this presentation are solely those of the author, Dr. Colleen Auchenbach
- Dr. Colleen and/or KMC University does not set practice standards
- We offer this only to educate and inform



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Objectives

- Identify areas where risks occur
- Utilize the components of self-auditing
- Demonstrate how to self-audit for compliance purposes
- Implement proactive steps to identify and address risks
- Distinguish between the various types of records requests and how to respond accordingly
- Develop an action list to lower your risk and be audit ready

3

Know the Messenger, Hear the Message

- Second generation chiropractor
- Practiced for over 20 years
- Completed 100 hour Insurance Consultant/Peer Review Certification
- Medical Compliance Specialist-Physician (MCS-P) 2016
- Joined KMC University 2020
- Certified Professional Medical Auditor (CPMA) 2022
- Director of Education 2024
- Certified Professional Compliance Officer (CPCO) 2024

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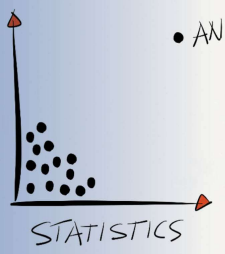
Why do providers continue to get audited?

- Unaware of Payer Policies and Updates
- Outlier Coding
- Data Analytics

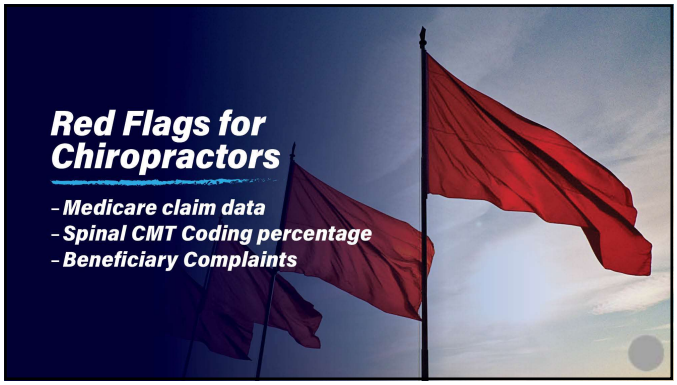
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Are You an Outlier?

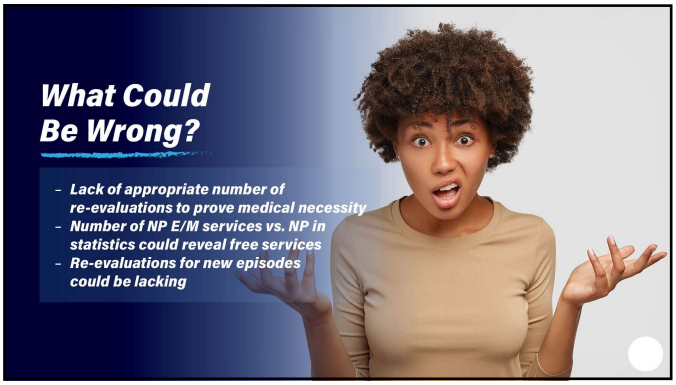
- Statistics tell us that the improper coding of full-spine treatment can cause you to appear to be an outlier
- You therefore can be subject to more scrutiny, red flags, and even an audit



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Red Flags for Chiropractors
- Medicare claim data
- Spinal CMT Coding percentage
- Beneficiary Complaints

7


What Could Be Wrong?
- Lack of appropriate number of re-evaluations to prove medical necessity
- Number of NP E/M services vs. NP in statistics could reveal free services
- Re-evaluations for new episodes could be lacking

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What Could Be Wrong?
- Full spine adjusting and billing
- Missing complaints in documentation
- Overuse of 98940 for cash
- Lack or inappropriate use of S8990
- Missing extraspinal adjustments

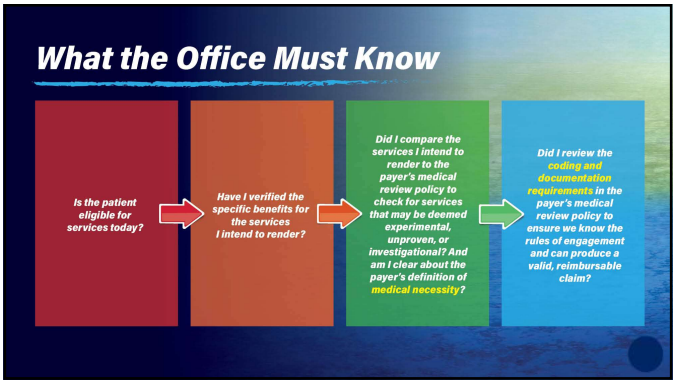
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Known Violations: Per OIG
- Submitted claims for services that were never provided
- Submitted claims for medically unnecessary services
- Offered incentives to patients to receive unnecessary services
- Provided services without a valid chiropractic license
- Falsified patient records, and
- Billed for chiropractic services but provided services not covered by Medicare (e.g., massage and acupuncture)

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Most Significant Compliance Risks We See
- Lack of understanding of the Big Four Steps to compliance as we see it
- Lack of differentiating medical necessity from clinical appropriateness
- Disconnecting from the rules of billing because "I'm the Provider of Service" not the biller
- The attitude that the rules don't apply to me because I run a cash practice
- And, by the way, I don't keep up with the rules because I'm too busy... but I try to belong to lots of random free Facebook groups to get my advice

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What the Office Must Know
Is the patient eligible for services today?
Have I verified the specific benefits for the services I intend to render?
Did I compare the services I intend to render to the payer's medical review policy to check for services that may be deemed experimental, unproven, or investigational? And am I clear about the payer's definition of medical necessity?
Did I review the coding and documentation requirements in the payer's medical review policy to ensure we know the rules of engagement and can produce a valid, reimbursable claim?

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Records Request

Take it Seriously

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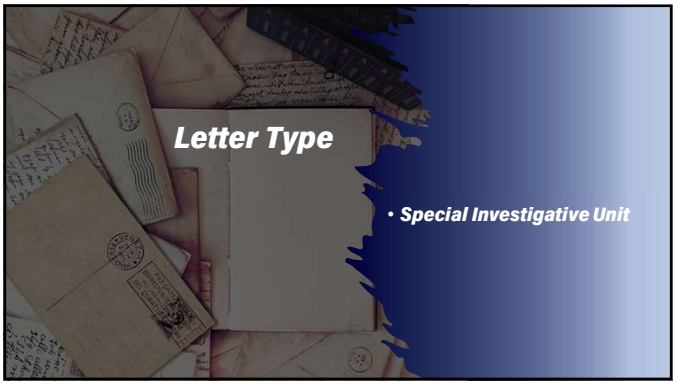


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Various Letter Types

- *Special Investigative Unit*
- *Risk Adjustment*
- *CERT Review*
- *Provider Education Audit*

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Thank you for participating with Sanford Health Plan. We appreciate the quality care you provide to our members.

Sanford Health Plan is committed to high quality, value-oriented healthcare. We continuously monitor the quality of care and services provided to our members. As part of this process, Sanford Health Plan conducts claims review audits before and after adjudication to ensure quality performance. These reviews fulfill diverse requirements including: HEDIS audits, NCQA, RADV-IVA data validation audit, Fraud/Waste/Abuse (FWA) investigations, focus audits, risk severity audits and others as deemed necessary.

Sanford's Provider Manual, Section 4.7.4, page 40, provides a right to review medical records. It provides:

> "Medical records may be requested by Sanford Health Plan in connection with utilization or quality improvement activities, or may be requested as verification to support a claim. Well documented medical records facilitate communication, coordination and continuity of care; and they promote the efficiency and effectiveness of treatment."

As such, the Special Investigations Unit (SIU) is required to conduct routine audits and reviews in accordance with regulatory guidelines to ensure that billed charges match the services provided to our members.

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Records Manager:

Wellmark Blue Cross and Blue Shield is conducting a post-payment review of member claims. Please submit complete medical records for each member, for the dates of service listed on the enclosed spreadsheet. Any and all documentation supporting the services must be submitted for review to determine if proper payment was made for the services billed.

Wellmark, as a local plan participating in the Blue Cross® and Blue Shield® Association's Federal Employee Program®, administers the plan on behalf of the Office of Personnel Management (OPM), an independent agency of the United States government. As part of contract CS1039 with OPM, Wellmark is required to investigate, identify, and recover inappropriate benefit payments on behalf of the federal government.

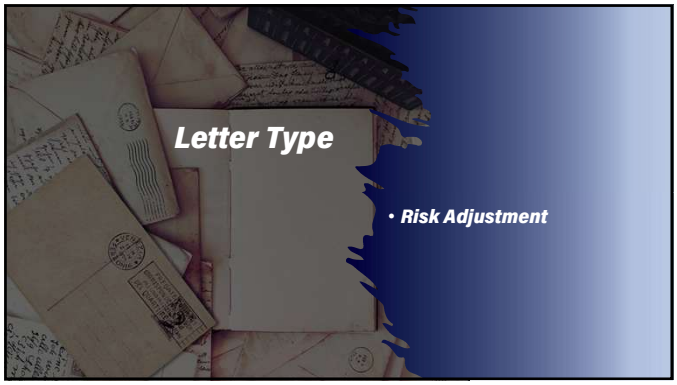
Please return a copy of this letter along with the requested documentation and the signed certification within 30 days

Wellmark does not make separate payment for copies of medical records necessary for processing claims for benefits. Our agreements with members and contracting providers state that Wellmark will have access to the records necessary to administer the benefits of our members. An additional release for medical records is not necessary. Failure to comply with this request could result in a denial of your claims.

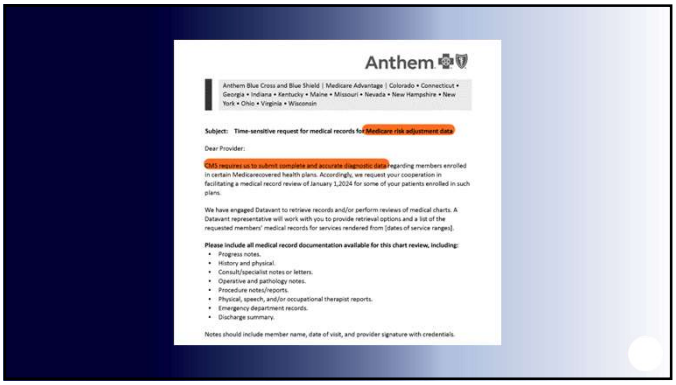
Sincerely,

Special Investigations Unit
Wellmark Blue Cross and Blue Shield

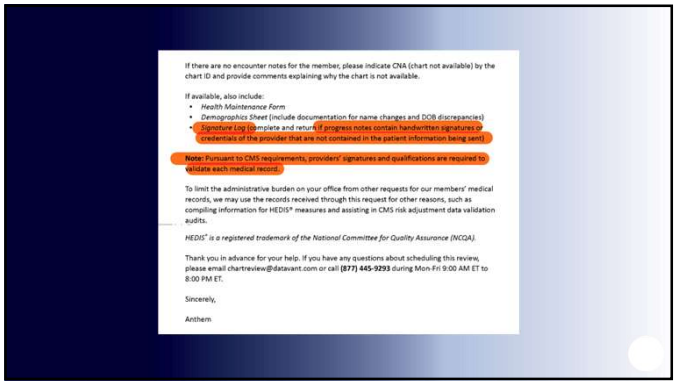
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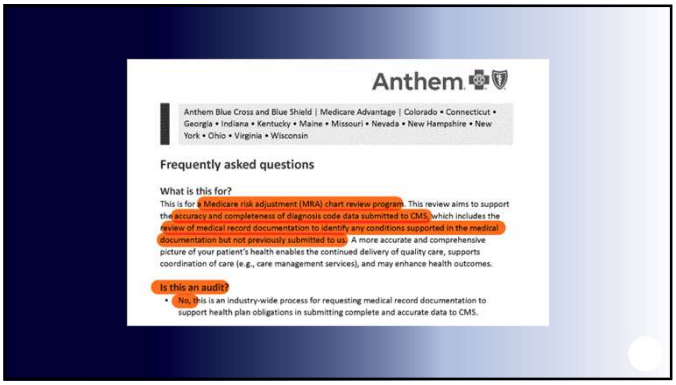
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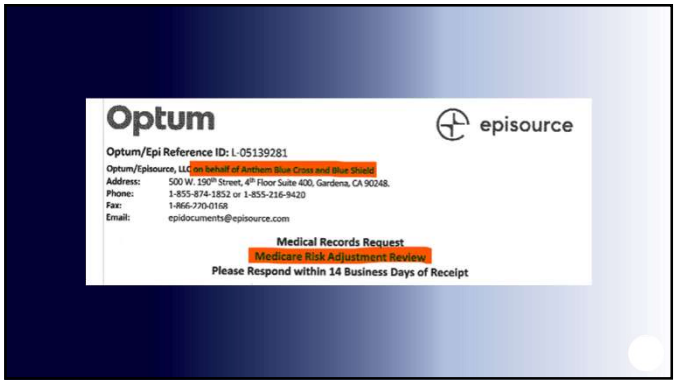
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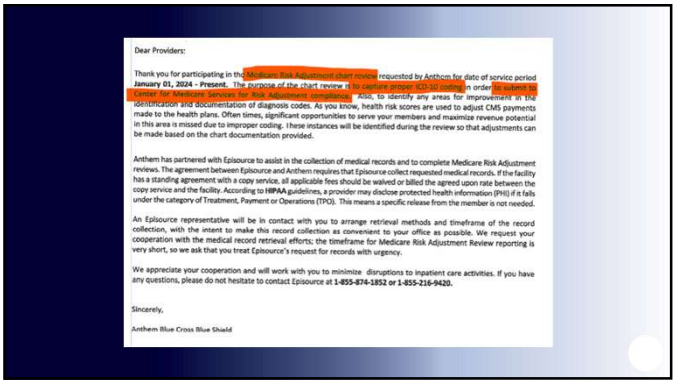
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BlueCross BlueShield of Alabama

Dear Provider:

Virtix Health, LLC has been contracted on behalf of Blue Cross and Blue Shield of Alabama to collect medical records[1]. The Centers for Medicare & Medicaid Services (CMS) and Department of Health and Human Services (HHS) require Medicare Advantage and Commercial plans to submit detailed documentation to support patient conditions. As outlined in your contract, you are required to respond to requests in support of risk adjustment, Healthcare Effectiveness Data and Information Set (HEDIS®) and other government required activities within a requested time frame. This includes Virtix's requests on behalf of Blue Cross and Blue Shield of Alabama.

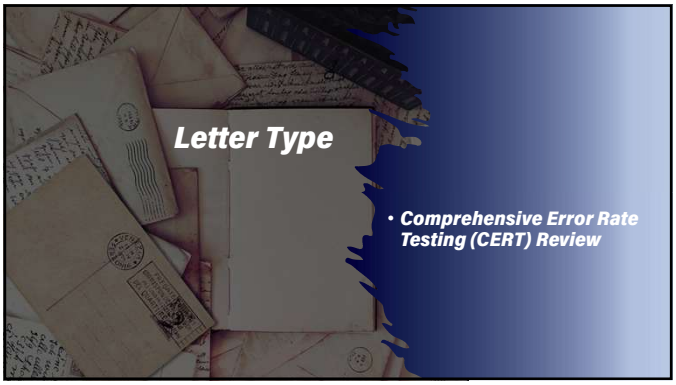
If you have questions about this request and process, please contact Virtix Health, LLC at 602-342-9838.

We appreciate your patience and assistance during this process.

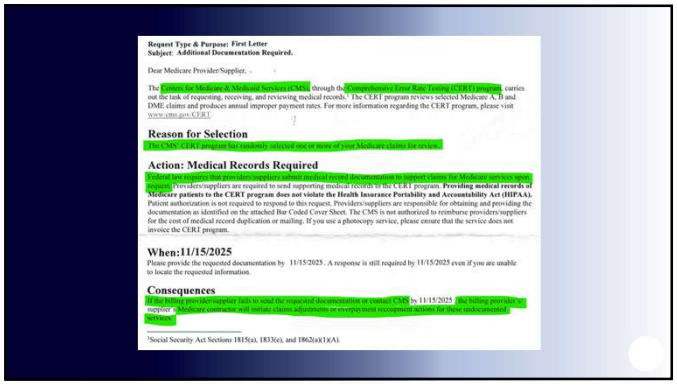
Thank you,

Blue Cross and Blue Shield of Alabama

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Request Type & Purpose: First Letter
Subject: Additional Documentation Required.

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS), through the Comprehensive Error Rate Testing (CERT) program, carries out the task of requesting, receiving, and reviewing medical records.[1] The CERT program reviews selected Medicare A, B and DME claims and produces annual improper payment rates. For more information regarding the CERT program, please visit www.cms.gov/CERT.

Reason for Selection

The CMS' CERT program has randomly selected one or more of your Medicare claims for review.

Action: Medical Records Required

Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to the CERT program. **Providing medical records of Medicare patients to the CERT program does not violate the Health Insurance Portability and Accountability Act (HIPAA).** Patient authorization is not required to respond to this request. Providers/suppliers are responsible for obtaining and providing the documentation as identified on the attached Bar Coded Cover Sheet. The CMS is not authorized to reimburse providers/suppliers for the cost of medical record duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT program.

When:11/15/2025

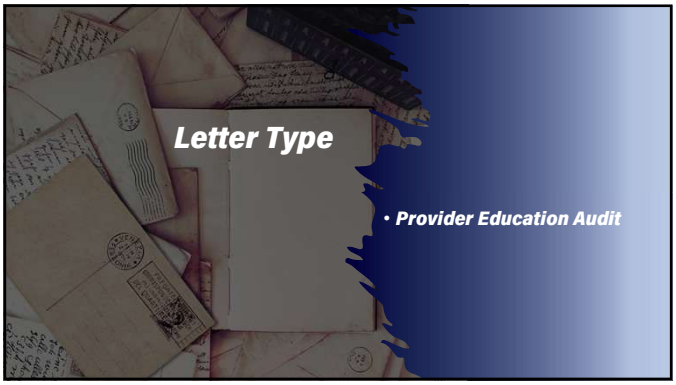
Please provide the requested documentation by 11/15/2025. A response is still required by 11/15/2025 even if you are unable to locate the requested information.

Consequences

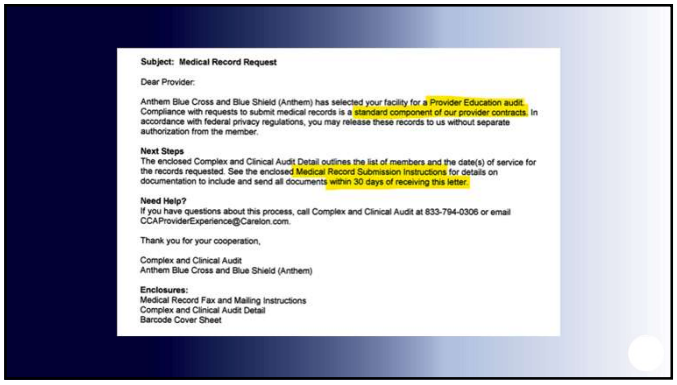
If the billing provider/supplier fails to send the requested documentation or contact CMS by 11/15/2025, the billing provider's/supplier's Medicare contractor will initiate claims adjustments or overpayment actions for these undocumented services.

[1]Social Security Act Sections 1815(a), 1833(e), and 1862(a)(1)(A).

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Subject: Medical Record Request

Dear Provider:

Anthem Blue Cross and Blue Shield (Anthem) has selected your facility for a Provider Education audit. Compliance with requests to submit medical records is a standard component of our provider contracts. In accordance with federal privacy regulations, you may release these records to us without separate authorization from the member.

Next Steps
The enclosed Complex and Clinical Audit Detail outlines the list of members and the date(s) of service for the records requested. See the enclosed Medical Record Submission Instructions for details on documentation to include and send all documents within 30 days of receiving this letter.

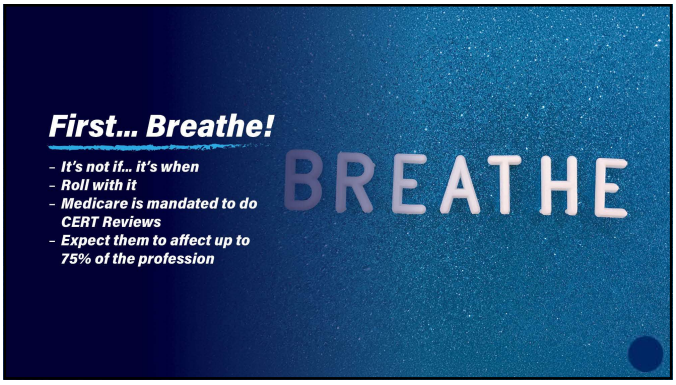
Need Help?
If you have questions about this process, call Complex and Clinical Audit at 833-794-0306 or email CCAProviderExperience@Carelon.com.

Thank you for your cooperation,

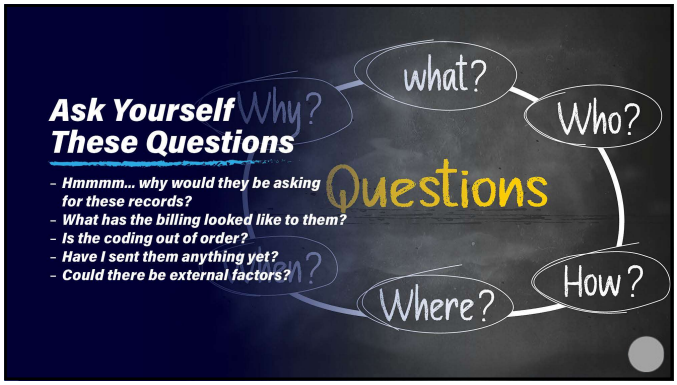
Complex and Clinical Audit
Anthem Blue Cross and Blue Shield (Anthem)

Enclosures:
Medical Record Fax and Mailing Instructions
Complex and Clinical Audit Detail
Barcode Cover Sheet

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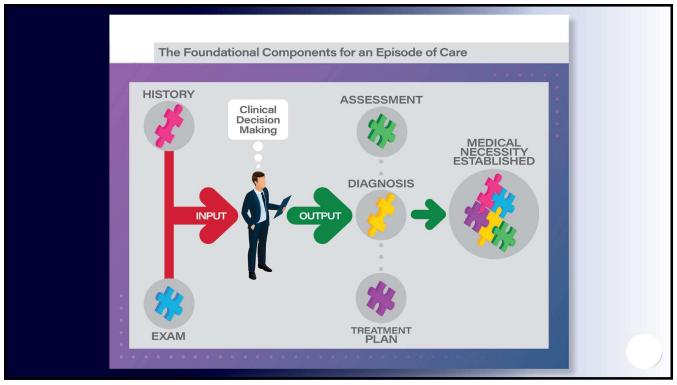
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Checks and Balances

MANAGEMENT STYLES



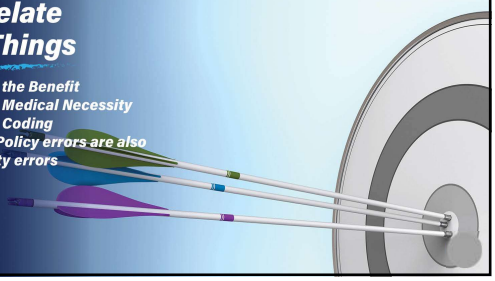
REACTIVE
Reacting to a problem after it arises.

PROACTIVE
Preventing problems before they arise.

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Denials Relate to Three Things

- Denied based on the Benefit
- Denied based on Medical Necessity
- Denied based on Coding
- Medical Review Policy errors are also Medical Necessity errors



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Rationale for Denials Are Two-Fold

Binding Rationale:
- Medical Policy Manual
- Medical Review Policy
- Local Coverage Determinations (LCD)
- Local Coverage Articles (LCA)
- National Coverage Determinations (NCD)

Persuasive Rationale:
- Generally Accepted Standards
- MedLearn Matters
- Best Practices
- KMC University
- American Chiropractic Association
- CPT Editorial Panel-CPT Books
- CPT Assistant Articles

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Common Audit Findings

- Missing signature
- Incorrect coding for what is being done
- Not documenting time for timed codes
- Lacking support for medical necessity
- Over coding spinal CMT
- No treatment plan
- Rationale not indicated

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CareFirst Audit Findings

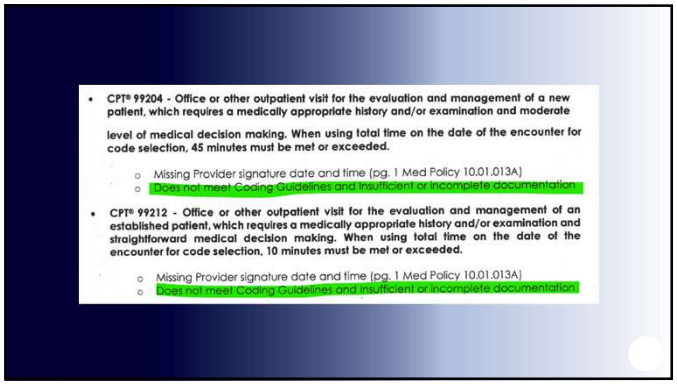
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Carefirst ¹ has reviewed the medical records you produced in response to our February 22, 2024, letter. This letter is to provide the audit findings for the records supplied by your office. Based on that review, we have determined that you were overpaid in the total amount of **$2,460.54.** CareFirst **is not** seeking reimbursement of the overpayment currently; however, has decided to provide these findings as an educational opportunity.

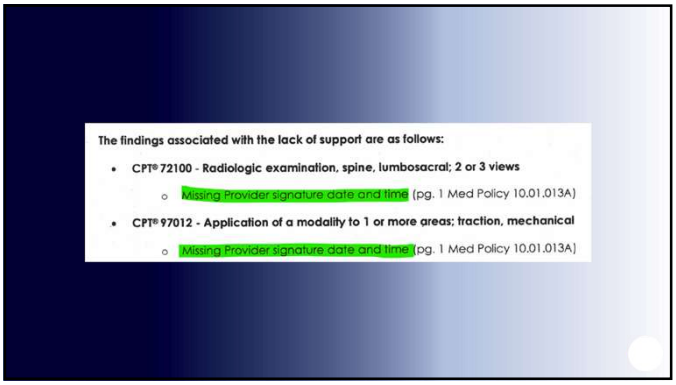
The review of your medical records generated the following:

Below are CareFirst's audit findings from our review of the medical records you provided for the requested thirty (30) members. The scope of the audit included claims with a payment date from December 1, 2022, through March 31, 2023. Our data indicated the medical records provided did not support proper coding and/or documentation for services on **one hundred-seventy (170) of one hundred-seventy (170) claims lines** billed to CareFirst, yielding a **100%** error rate. Overall, all claim lines found to be improperly coded and/or documented resulted in the overpayment amount of **$2460.54.**

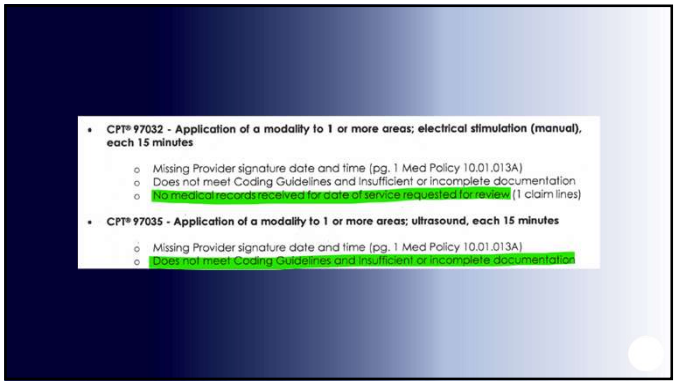
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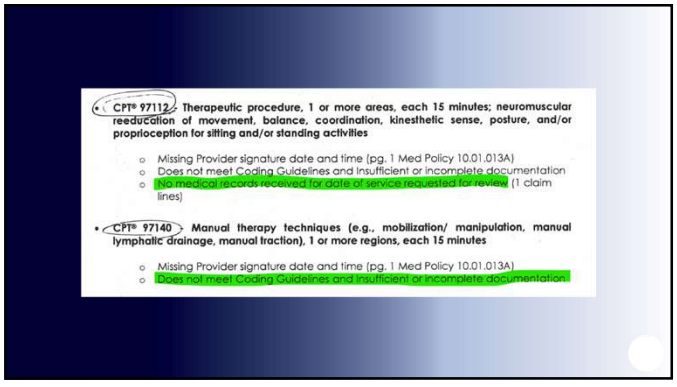
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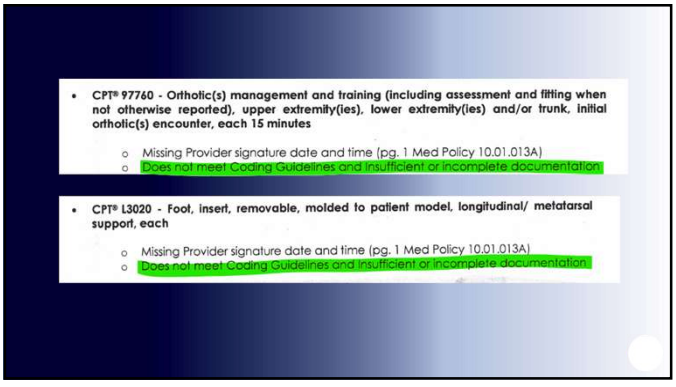
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Your practice is being scheduled for a compliance audit in the next six months to verify that the billing issues discussed above have been addressed and that your practice is complying with all applicable coding guidelines, CareFirst's medical policies and your provider contract(s). If the issue is not corrected, CareFirst reserves its rights to pursue recovery of the overpayments identified in this letter, as well as any additional overpayments. If you have any questions, contact me at

Sincerely,

Investigator
Special Investigations Unit
Corporate Risk Assurance

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The records that were submitted on your behalf have been reviewed to determine if proper payments were made. The review was completed by ManagingCare, ManagingClaims (MCMC), a privately owned peer review organization that reviews medical records submitted by Wellmark Blue Cross and Blue Shield MCMC's focus is to make a professional, independent, and unbiased decision.

Results of the review

Enclosed is a copy of the full review Wellmark received and a spreadsheet of impacted claims. Based on the opinion of reviewer it has been determined that you have been overpaid $9,427.82 by Wellmark.

This overpayment may represent inappropriate benefit payments for individuals covered by the Federal Employees Health Benefit Plan (FEHBP). Wellmark, via Blue Cross® and Blue Shield® Association's Federal Employee Program®, administers the FEHBP on behalf of the Office of Personnel Management (OPM), an independent agency of the United States government. As a part of the contract with OPM, Wellmark is required to investigate, identify, and recover inappropriate benefit payments on behalf of the federal government.

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You may appeal this decision

With this letter, you are being informed of the initial review findings. If you disagree with the review findings, you may now submit an appeal. If you have additional documentation which would substantiate the claim(s) as originally submitted or affect the calculation of the overpaid amount, please provide that documentation so it can be included in your appeal. Your appeal and any additional documentation must be received within 30 days from receipt of this letter. The appeal will be reviewed by a medical professional with the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment under review. The appeal determination is final.

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If you choose not to appeal

If you do not file an appeal within 30 days from receipt of this letter, Wellmark considers this your acknowledgement of the $9,427.82 overpayment amount.

You may choose to pay by check or advise Wellmark to begin holding your payments and applying them to the outstanding accounts receivable (AR) balance of $9,427.82 until the outstanding AR balance is satisfied. If we do not receive a check for the full overpaid amount or notification to begin holding your payments within 30 days from receipt of this letter, Wellmark will begin automatically recouping the overpayment.

A provider claims remittance (PCR) and/or electronic remittance advice (ERA) will be available to show the breakdown of recoupment payments. Due to copayments, coinsurance, and other plan provisions that could impact the claim adjustments, the overpayment amount may be more or less than requested. Following adjustment of these claims, if the overpayment is greater than the amount identified above, Wellmark will either request the additional overpayment through your PCRs or recoup the additional overpayment from future claim payments. If the overpayment is less, Wellmark will return the excess amount.

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Your records may be subject to ongoing review. Failure to comply with Special Investigations Unit reviews or engaging in other improper billing conduct may lead to termination of your in-network status. It is Wellmark's expectation that you comply with the education provided by the reviewer in the enclosed report when submitting future claims.

Thank you for your assistance.

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Sanford Health Plan (SHP) recently identified claims submitted from your practice that required further review to ensure the documentation and services provided supported the claims billed under SHP. SHP requested a sample of medical records from your practice to ensure the documentation and services provided were supported.

Your practice was flagged as an outlier due to the use of codes 98943 per claim compared to your peers. The investigative team conducted a review of these submitted claims. Review of the medical records identified the following deficiencies:

- 98943 unsupported for ribs – According to AMA CPT rules, the thoracic region includes the costovertebral and costotransverse joints. The medical records indicated that extraspinal manipulation was performed on thoracic region ribs. As these rib joints are included in the thoracic region for codes 98940-98942, and the records did not specify exactly what part of ribs was manipulated, we are unable to support the use of code 98943 for ribs alone.

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determined the recoupment amount to be $566.10.

Sanford Health Plan has expectations that providers utilize correct coding guidelines with all necessary supportive documentation noted in each member's record. Medical records may be requested by Sanford Health Plan in connection with utilization or quality improvement activities or may be requested as verification to support a claim. Well documented medical records facilitate communication, coordination and continuity of care; and they promote the efficiency and effectiveness of treatment.

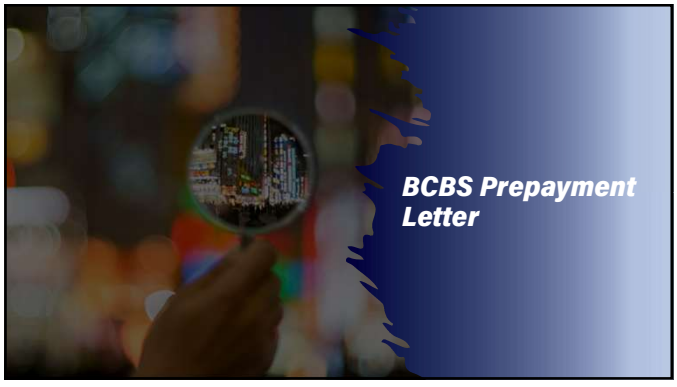
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Should you disagree with this determination, you may submit a dispute in writing. To dispute, you must submit a detailed appeal in writing along with any relevant information within 30 calendar days of the date of this letter. Recoupment and claims adjustments will begin after the 30 calendar days if no dispute is received. You may submit additional documentation to further substantiate your claim(s). Please contact us at siu.compliance@sanfordhealth.org to dispute this determination. To submit a corrected claim, please see your provider manual for detailed instructions. Please see the included attachment for claims determinations. Thank you for your cooperation in this audit. If you have any questions, please reach out. The Special Investigations Unit can be reached by email at SIU.compliance@sanfordhealth.org.

Sincerely,

SIU/Compliance Department
Sanford Health Plan

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Blue Cross and Blue Shield of Oklahoma (BCBSOK), a Division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, conducts audits to identify duplicate or erroneous payments made by BCBSOK for services billed by providers. BCBSOK is responsible for review and oversight of claim payments, including those made on behalf of the federal government through the Federal Employee Program.

A provider performing covered services for a Blue Cross and Blue Shield member is responsible for all statements made on any claim form submitted to BCBSOK by or on the Provider's behalf. A Provider is responsible for the actions of its billing staff, whether employed or contracted. **It is imperative you ensure that all services billed to BCBSOK by your practice have actually been provided to our members and are appropriately documented. Any noncompliance of this nature must be immediately and permanently cured.**

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Pursuant to the issues addressed in our August 11, 2023, letter to you, which have continued after receipt of that letter, this letter serves to inform you that effective April 23,2024, claims for all CPT and HCPCS codes will be subject to prepayment review. The purpose of this review is to ensure that claims meet the guidelines for adjudication according to BlueCross BlueShield of Oklahoma (BCBSOK) members' benefits, BCBSOK Medical Policies, and nationally accepted coding and documentation practices. Each claim submitted will trigger a letter to your office requesting records and a method to provide the records. Submit a copy of the request letter with any records furnished for review.

The Special Investigations Department of BCBSOK works with providers to resolve billing issues, reduce or eliminate future payment concerns, and recover past overpayments. Please be advised that a failure to resolve these issues may result in further audit activities, collection actions and/or claim offsets.

Respectfully,

Senior Fraud Investigator

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ACN Group of California, Inc. dba. OptumHealth Physical Health of California ("OptumHealth") believes it should be the goal of every practitioner to provide care that is aligned with current best practices. All stakeholders benefit from patients receiving care of the highest quality.

One method of ensuring that quality care is delivered to patients is by conducting provider record audits. OptumHealth performs audits with the intent to confirm that health care records are complete and accurate including the patient's language preferences. Additionally, audits assist in ensuring that health care providers are accountable to meet professional standards, contractual and regulatory requirements. In order to accomplish this OptumHealth has developed and instituted a record audit program.

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OptumHealth has recently evaluated records provided by your office, and has determined that the records do not meet basic professional standards as well as contractual and regulatory requirements. Specifically, such deficits violate the OptumHealth Provider Participation Agreement ("Agreement") in section 7.2, "Maintenance of and ACN Access to Records" and section 3.6 Quality Improvement Program. ***As a result of the findings of this audit, we are requiring that you participate in a Performance Improvement Program***, as set forth in the Agreement section 3.5 Compliance with Performance Improvement Agreements Issued by OptumHealth. Failure to complete this Performance Improvement Program may result in adverse action on your contract and participating provider status.

For your convenience, we have included a copy of the Record Audit Instrument used to review the records you provided. We ask that you carefully review this document and **implement changes to the areas noted as "not present"** or otherwise noted as deficient in some fashion.

64

Clinical resources available on the Optum Web site related to the California record audit are located under "Clinical Resources>Clinical Guidelines>CA Record Audit Information" and include:

- Clinical Policy 474 - Patient Healthcare Records Documentation Requirements for Utilization Review and File Audits
- Clinical Guidelines – CA Record Audit Info
- Optum Operations Manual – Provider Obligations – Medical Records
- Other useful clinical links to evidence-based references

Other useful resources include:

- National Committee for Quality Assurance (NCQA) – Patient-Centered Medical Home (PCMH) initiative
- Professional Association recommendations on recordkeeping
- Recordkeeping continuing education programs supported/sponsored by professional educational institutions
- Record Audit Instrument Reviewer Guide and Glossary (*enclosed with this letter*).

65

Improvement Goal and Performance Improvement Program Timeframe: *We will conduct a follow-up audit in approximately six months. A successful follow-up audit will require a passing score based upon the elements listed in the provided Record Audit Instrument. The record review scale is included in the upper right corner of the Record Audit Instrument.*

Potential Outcomes: The goal of the Performance Improvement Program is to assist practitioners incorporating current best evidence into practice. The requested enhancements in the quality of provider recordkeeping will benefit the patients being seen by your office. The majority of practitioners participating in the Performance Improvement Program successfully achieve the improvement goals stated within this agreement.

Practitioners who do not achieve the improvement goals, or who elect not to participate in the Performance Improvement Program are subject to additional required actions (*if applicable*) or possible remediation up to and including termination from the network.

66



67

To help safeguard Wisconsin Medicaid and BadgerCare Plus programs from unnecessary expenditures, service overutilization, and other compliance issues, the Wisconsin Department of Health Services (DHS) - Office of the Inspector General (OIG) is authorized under Wis. Admin Code DHS 106.11 to review specific claims from ForwardHealth providers prior to payment, which is known as Pre-Payment Review.

68

How to Identify Claims that Require Attachments

1. Find the claim's Payment Integrity Review Warning message;
2. Select Ignore in the upper right-hand corner;
3. Click Continue, which is centered at the bottom; and
4. Access Provider Claims Submission User Guides for instructions on uploading attachments.

If the process is **not** completed within seven (7) calendar days, the submitted claim will be denied. Should this occur, providers will be required to submit a new claim with the necessary supportive documentation attached to substantiate payment.

69

What Providers Must Know About Supportive Documentation

When submitting claim attachments for billing purposes, please remember that providers are expected to substantiate the type and amount of services rendered by attaching all available and relevant documentation in accordance with ForwardHealth rules and regulations. The following are examples of documentation providers may attach to the claim. However, this list is not exhaustive and providers may submit any documentation available that may substantiate payment.

- Case management or consultation notes
- Face-to-face encounter documentation
- Durable medical equipment or supply delivery receipts or proof of delivery and itemized invoices or bills
- Individualized plans of care and updates
- Initial or program assessments and questionnaires to indicate start DOS
- Office visit documentation
- Operative reports
- Prescriptions or test orders
- Session or service notes for each DOS
- Testing and lab results
- Transportation logs
- Treatment notes

For information about claim decisions, including denial reasons or additional documentation requests, please refer to the Remittance Advice (RA) - Claims Processing section(s) in the ForwardHealth Portal and review the Explanation of Benefit (EOB) codes.

70

How to Successfully Exit Pre-Payment Review Status

It is important to note that Pre-Payment Review enables providers to submit payable claims with the necessary supportive documentation while working with the OIG to address specific billing and compliance issues. Throughout this process, the OIG will communicate with providers regarding their Pre-Payment Review status, and will consider successfully exiting providers that:

- Continue billing claims with minimal fluctuations in average billing volume of no less than 10%; and
- Ensure at least 75% of submitted claims are payable.

71

Conclusion

Thank you for your commitment to providing Wisconsin Medicaid and BadgerCare Plus members with quality care and helping ensure the integrity of these vital programs. As we work together to resolve billing compliance issues through the Pre-Payment Review process, the OIG encourages providers to utilize these additional resources:

- Refer to ForwardHealth Handbook Topics #22797 and #22798 to learn more about Pre-Payment Reviews.
- Explore ForwardHealth Online Handbook claims chapters for requirements, processes, and much more.

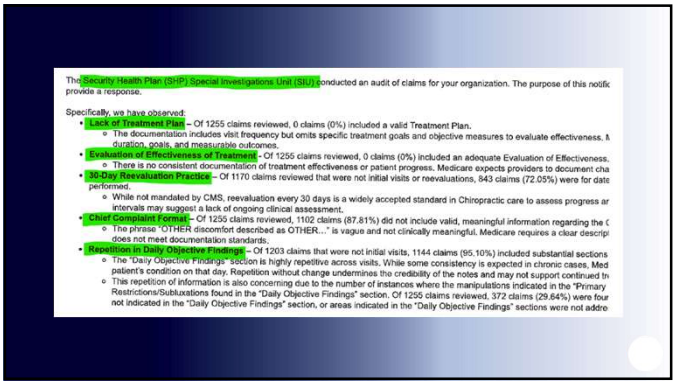
Sincerely,

Office of the Inspector General
Department of Health Services

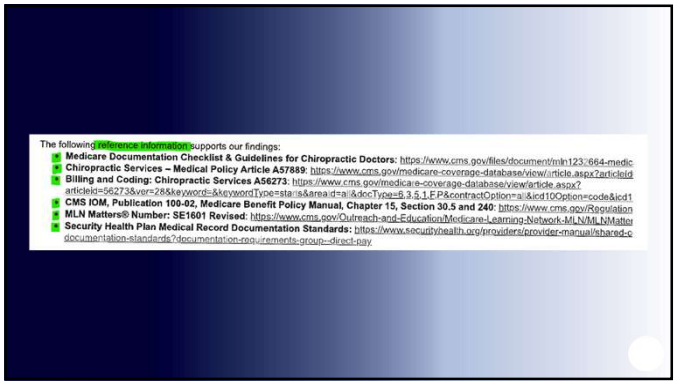
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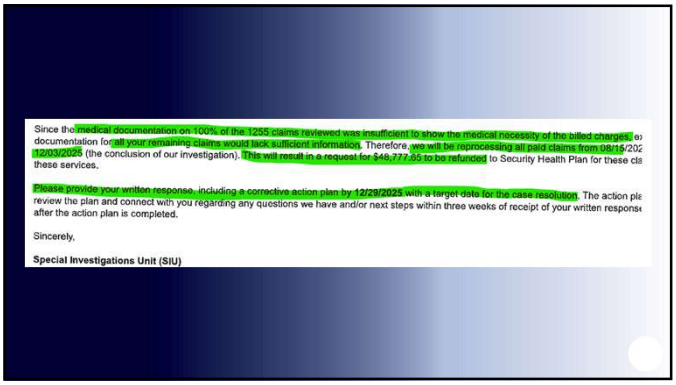
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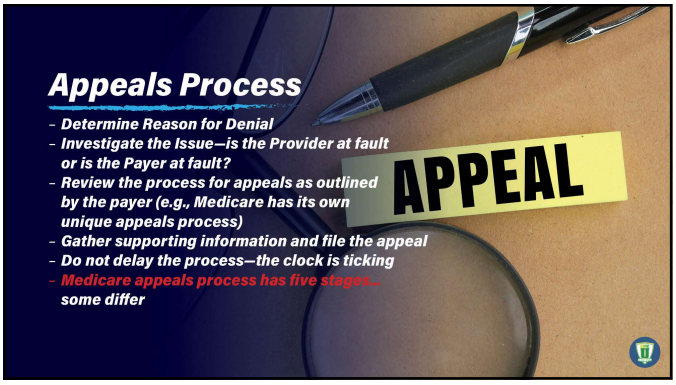
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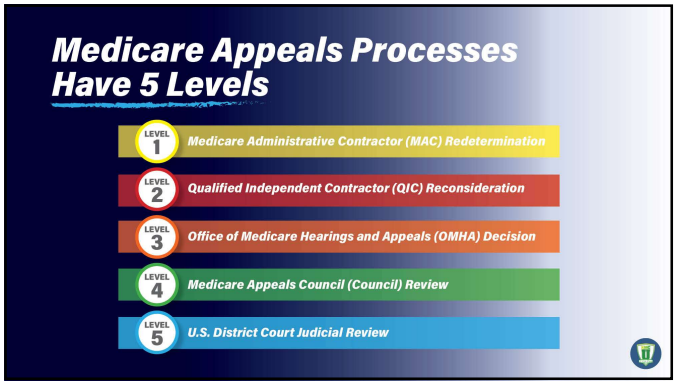
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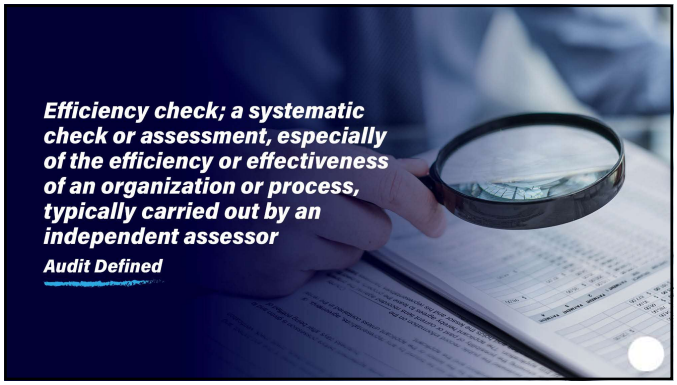
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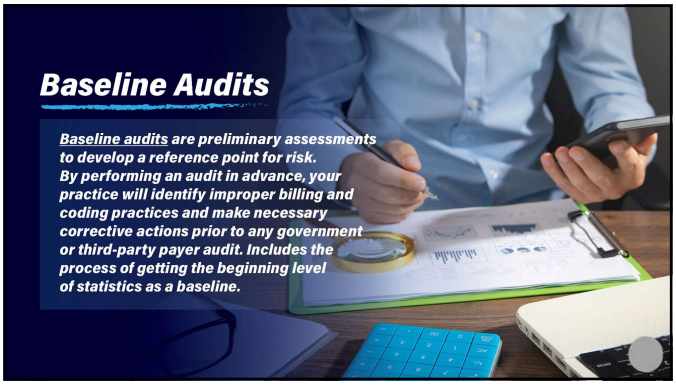
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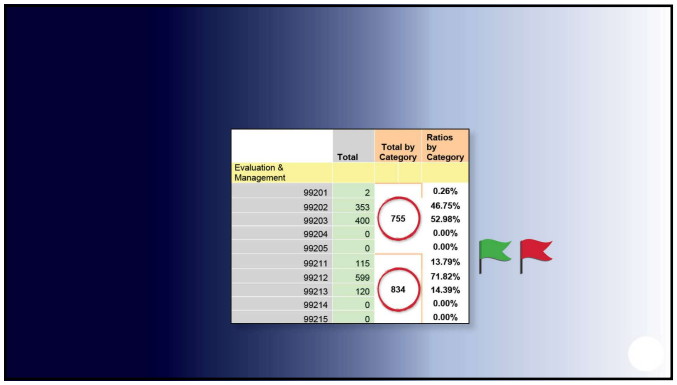
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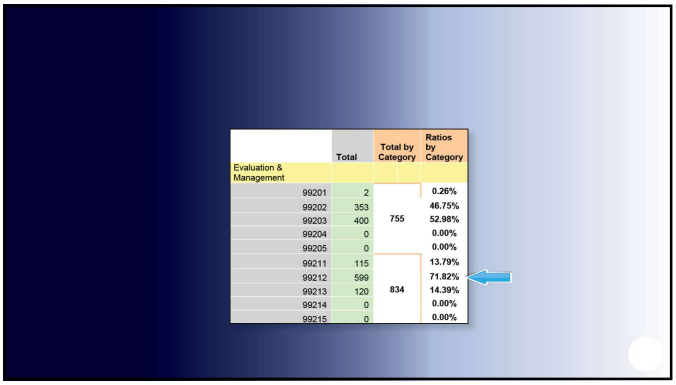


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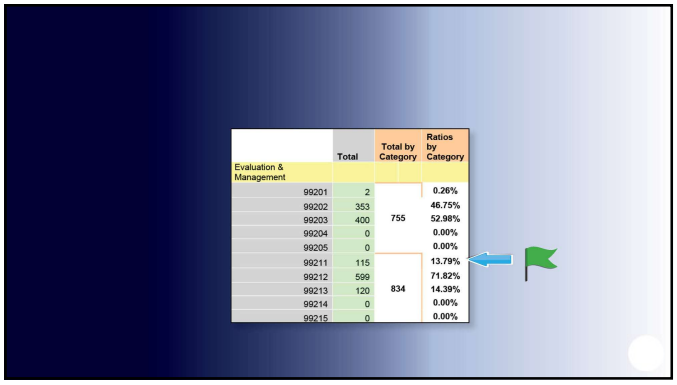
	Total	Total by Category	Ratios by Category
Evaluation & Management			
99201	2	755	0.26%
99202	353		46.75%
99203	400		52.98%
99204	0		0.00%
99205	0		0.00%
99211	115	834	13.79%
99212	599		71.82%
99213	120		14.39%
99214	0		0.00%
99215	0		0.00%

93



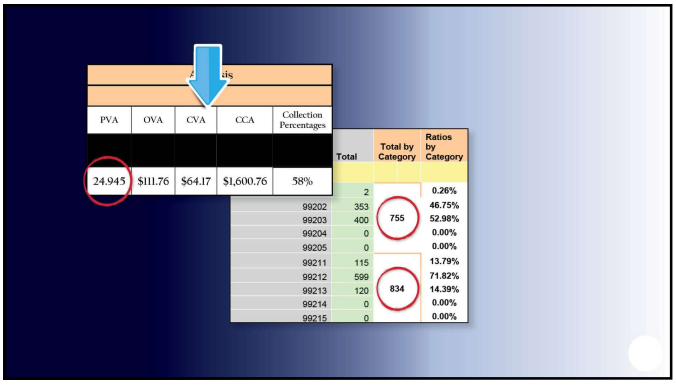
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99212	599		71.82%
99213	120		14.39%
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99215	0		0.00%

94



	Total	Total by Category	Ratios by Category
Evaluation & Management			
99201	2	755	0.26%
99202	353		46.75%
99203	400		52.98%
99204	0		0.00%
99205	0		0.00%
99211	115	834	13.79%
99212	599		71.82%
99213	120		14.39%
99214	0		0.00%
99215	0		0.00%

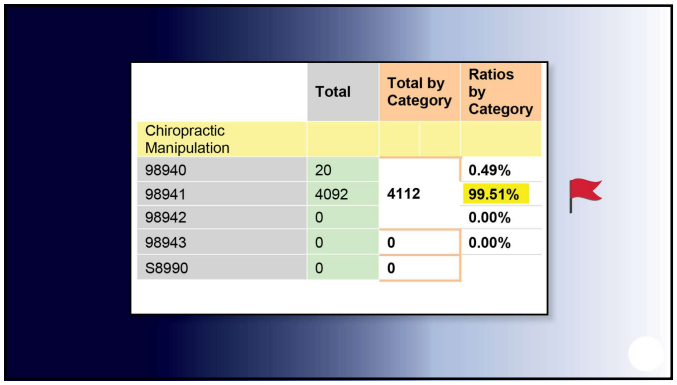
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PVA	OVA	CVA	CCA	Collection Percentages
24.945	$111.76	$64.17	$1,600.76	58%

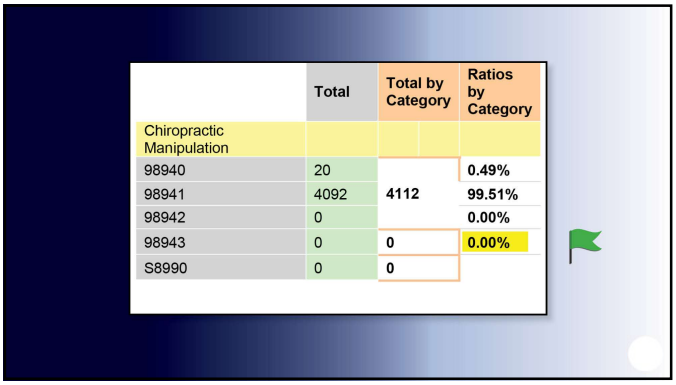
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99202	353		46.75%
99203	400		52.98%
99204	0		0.00%
99205	0		0.00%
99211	115	834	13.79%
99212	599		71.82%
99213	120		14.39%
99214	0		0.00%
99215	0		0.00%

96



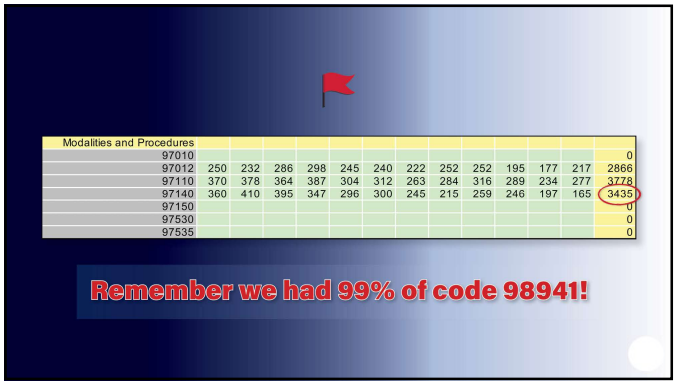
	Total	Total by Category	Ratios by Category
Chiropractic Manipulation			
98940	20		0.49%
98941	4092	4112	99.51%
98942	0		0.00%
98943	0	0	0.00%
S8990	0	0	

97



	Total	Total by Category	Ratios by Category
Chiropractic Manipulation			
98940	20		0.49%
98941	4092	4112	99.51%
98942	0		0.00%
98943	0	0	0.00%
S8990	0	0	

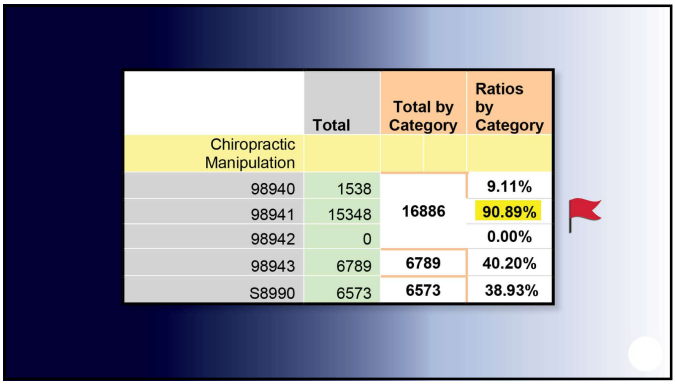
98



Modalities and Procedures													
97010													0
97012	250	232	286	298	245	240	222	252	252	195	177	217	2866
97110	370	378	364	387	304	312	263	284	316	289	234	277	3778
97140	360	410	395	347	296	300	245	215	259	246	197	165	3435
97150													0
97530													0
97535													0

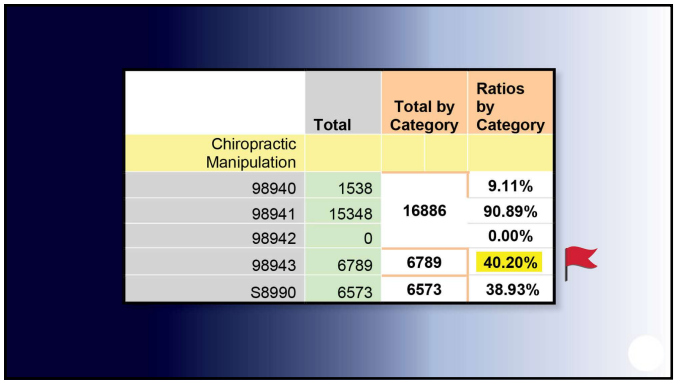
Remember we had 99% of code 98941!

99



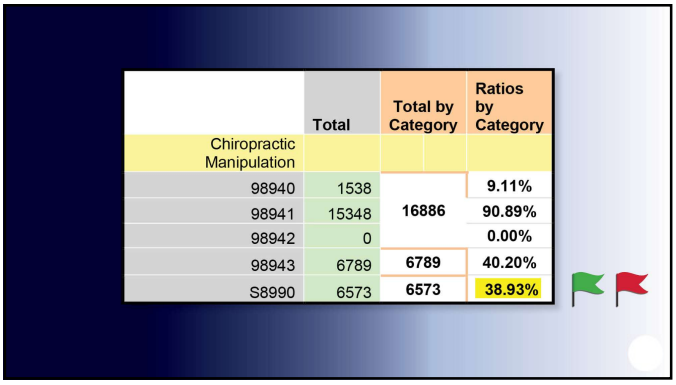
	Total	Total by Category	Ratios by Category
Chiropractic Manipulation			
98940	1538		9.11%
98941	15348	16886	90.89%
98942	0		0.00%
98943	6789	6789	40.20%
S8990	6573	6573	38.93%

100



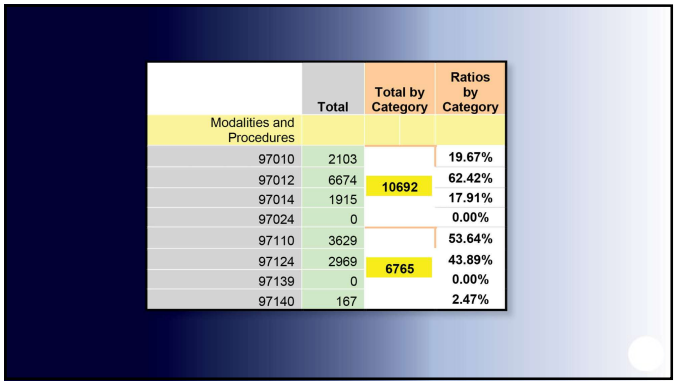
	Total	Total by Category	Ratios by Category
Chiropractic Manipulation			
98940	1538		9.11%
98941	15348	16886	90.89%
98942	0		0.00%
98943	6789	6789	40.20%
S8990	6573	6573	38.93%

101



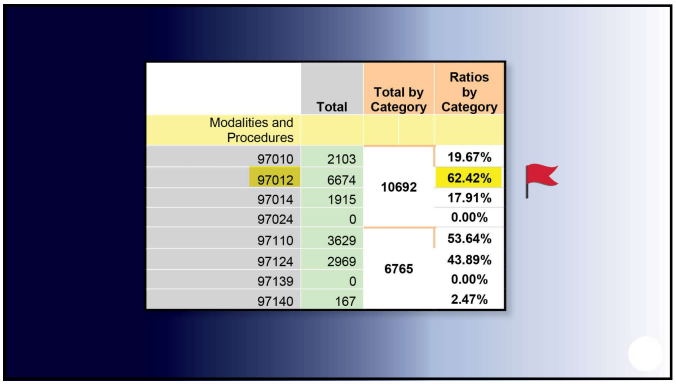
	Total	Total by Category	Ratios by Category
Chiropractic Manipulation			
98940	1538		9.11%
98941	15348	16886	90.89%
98942	0		0.00%
98943	6789	6789	40.20%
S8990	6573	6573	38.93%

102



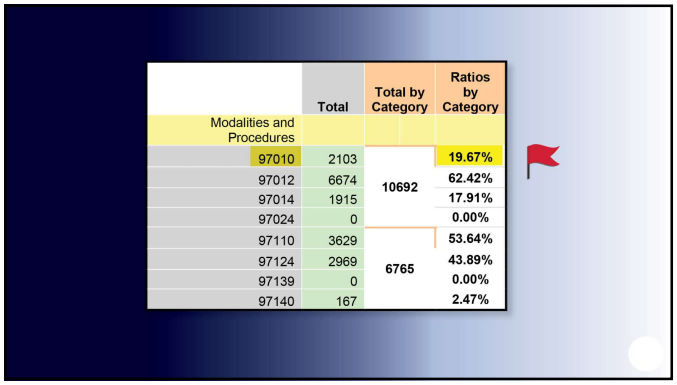
Modalities and Procedures	Total	Total by Category	Ratios by Category
97010	2103		19.67%
97012	6674	10692	62.42%
97014	1915		17.91%
97024	0		0.00%
97110	3629		53.64%
97124	2969	6765	43.89%
97139	0		0.00%
97140	167		2.47%

103



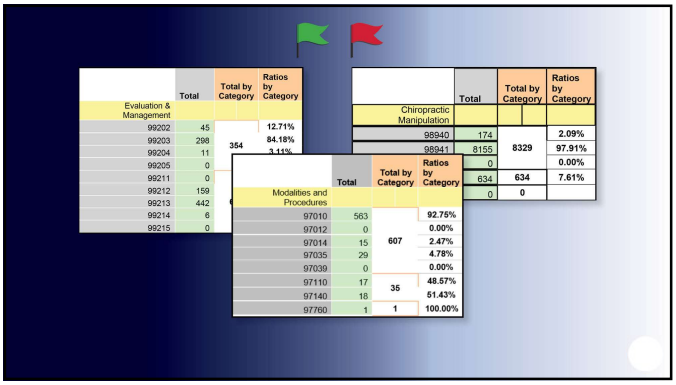
Modalities and Procedures	Total	Total by Category	Ratios by Category
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97012	6674		62.42%
97014	1915		17.91%
97024	0		0.00%
97110	3629	6765	53.64%
97124	2969		43.89%
97139	0		0.00%
97140	167		2.47%

104



Modalities and Procedures	Total	Total by Category	Ratios by Category
97010	2103	10692	19.67%
97012	6674		62.42%
97014	1915		17.91%
97024	0		0.00%
97110	3629	6765	53.64%
97124	2969		43.89%
97139	0		0.00%
97140	167		2.47%

105



Evaluation & Management	Total	Total by Category	Ratios by Category
99202	45	354	12.71%
99203	298		84.18%
99204	11		3.11%
99205	0		
99211	0		
99212	159		
99213	442		
99214	6		
99215	0		

Chiropractic Manipulation	Total	Total by Category	Ratios by Category
98940	174	8329	2.09%
98941	8155		97.91%
	0		0.00%
	634	634	7.61%
	0	0	

Modalities and Procedures	Total	Total by Category	Ratios by Category
97010	563	607	92.75%
97012	0		0.00%
97014	15		2.47%
97035	29		4.78%
97039	0		0.00%
97110	17	35	48.57%
97140	18		51.43%
97760	1	1	100.00%

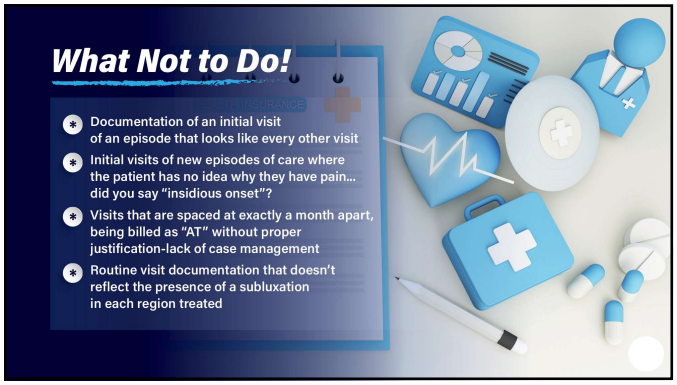
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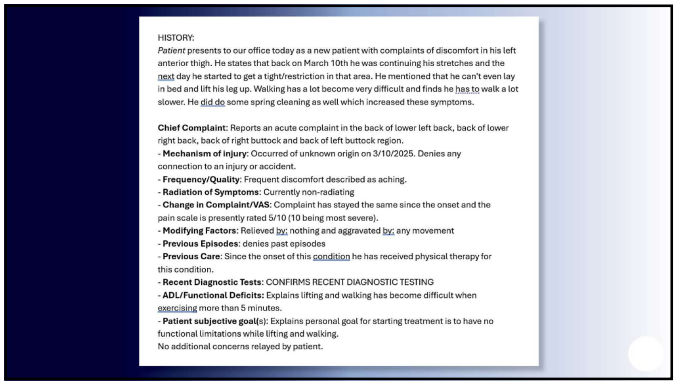
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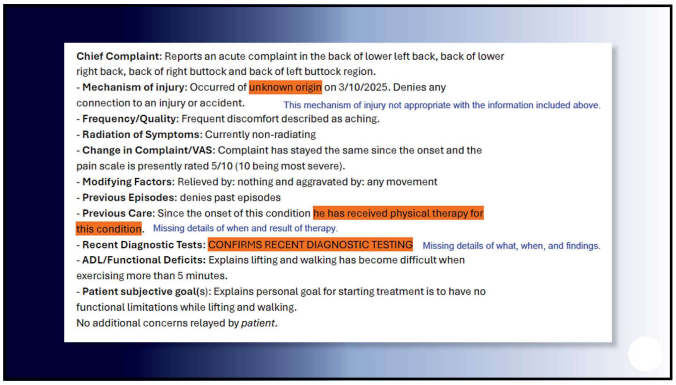
110



HISTORY:
Patient presents to our office today as a new patient with complaints of discomfort in his left anterior thigh. He states that back on March 10th he was continuing his stretches and the next day he started to get a tight/restriction in that area. He mentioned that he can't even lay in bed and lift his leg up. Walking has a lot become very difficult and finds he has to walk a lot slower. He did do some spring cleaning as well which increased these symptoms.

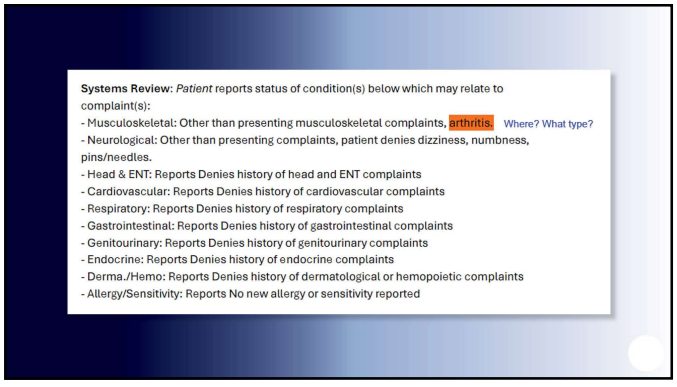
Chief Complaint: Reports an acute complaint in the back of lower left back, back of lower right back, back of right buttock and back of left buttock region.
- **Mechanism of injury:** Occurred of unknown origin on 3/10/2025. Denies any connection to an injury or accident.
- **Frequency/Quality:** Frequent discomfort described as aching.
- **Radiation of Symptoms:** Currently non-radiating
- **Change in Complaint/VAS:** Complaint has stayed the same since the onset and the pain scale is presently rated 5/10 (10 being most severe).
- **Modifying Factors:** Relieved by: nothing and aggravated by: any movement
- **Previous Episodes:** denies past episodes
- **Previous Care:** Since the onset of this condition he has received physical therapy for this condition.
- **Recent Diagnostic Tests:** CONFIRMS RECENT DIAGNOSTIC TESTING
- **ADL/Functional Deficits:** Explains lifting and walking has become difficult when exercising more than 5 minutes.
- **Patient subjective goal(s):** Explains personal goal for starting treatment is to have no functional limitations while lifting and walking.
No additional concerns relayed by patient.

111



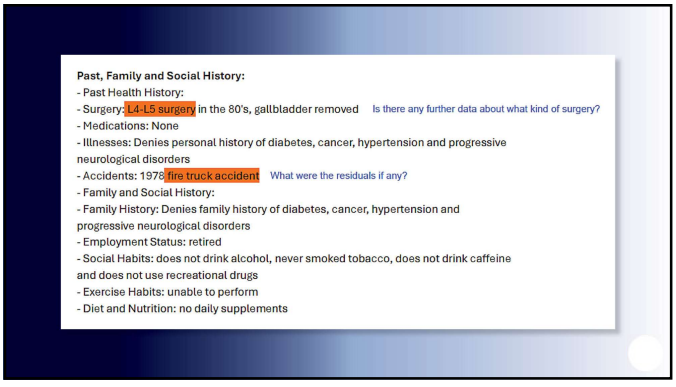
Chief Complaint: Reports an acute complaint in the back of lower left back, back of lower right back, back of right buttock and back of left buttock region.
- **Mechanism of injury:** Occurred of unknown origin on 3/10/2025. Denies any connection to an injury or accident. This mechanism of injury not appropriate with the information included above.
- **Frequency/Quality:** Frequent discomfort described as aching.
- **Radiation of Symptoms:** Currently non-radiating
- **Change in Complaint/VAS:** Complaint has stayed the same since the onset and the pain scale is presently rated 5/10 (10 being most severe).
- **Modifying Factors:** Relieved by: nothing and aggravated by: any movement
- **Previous Episodes:** denies past episodes
- **Previous Care:** Since the onset of this condition he has received physical therapy for this condition. Missing details of when and result of therapy.
- **Recent Diagnostic Tests:** CONFIRMS RECENT DIAGNOSTIC TESTING Missing details of what, when, and findings.
- **ADL/Functional Deficits:** Explains lifting and walking has become difficult when exercising more than 5 minutes.
- **Patient subjective goal(s):** Explains personal goal for starting treatment is to have no functional limitations while lifting and walking.
No additional concerns relayed by *patient*.

112



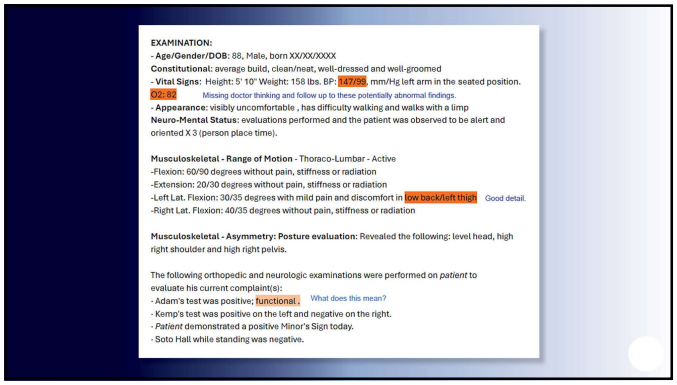
Systems Review: *Patient* reports status of condition(s) below which may relate to complaint(s):
- Musculoskeletal: Other than presenting musculoskeletal complaints, arthritis. Where? What type?
- Neurological: Other than presenting complaints, patient denies dizziness, numbness, pins/needles.
- Head & ENT: Reports Denies history of head and ENT complaints
- Cardiovascular: Reports Denies history of cardiovascular complaints
- Respiratory: Reports Denies history of respiratory complaints
- Gastrointestinal: Reports Denies history of gastrointestinal complaints
- Genitourinary: Reports Denies history of genitourinary complaints
- Endocrine: Reports Denies history of endocrine complaints
- Derma./Hemo: Reports Denies history of dermatological or hemopoietic complaints
- Allergy/Sensitivity: Reports No new allergy or sensitivity reported

113

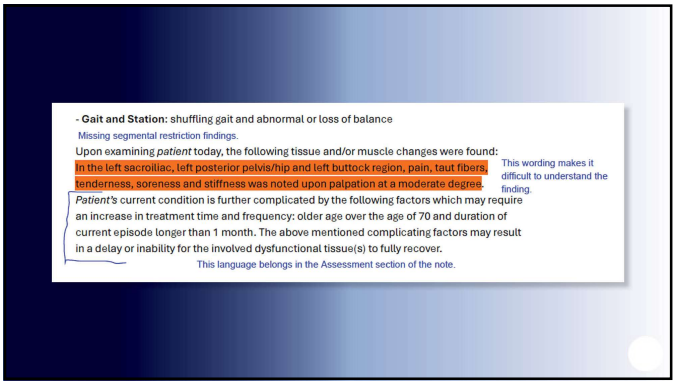


Past, Family and Social History:
- Past Health History:
- Surgery: L4-L5 surgery in the 80's, gallbladder removed Is there any further data about what kind of surgery?
- Medications: None
- Illnesses: Denies personal history of diabetes, cancer, hypertension and progressive neurological disorders
- Accidents: 1978 fire truck accident What were the residuals if any?
- Family and Social History:
- Family History: Denies family history of diabetes, cancer, hypertension and progressive neurological disorders
- Employment Status: retired
- Social Habits: does not drink alcohol, never smoked tobacco, does not drink caffeine and does not use recreational drugs
- Exercise Habits: unable to perform
- Diet and Nutrition: no daily supplements

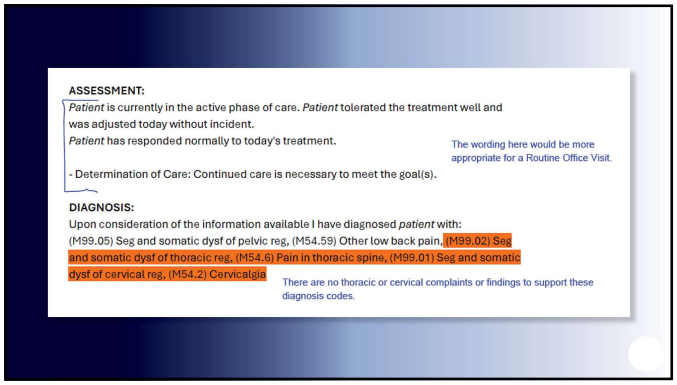
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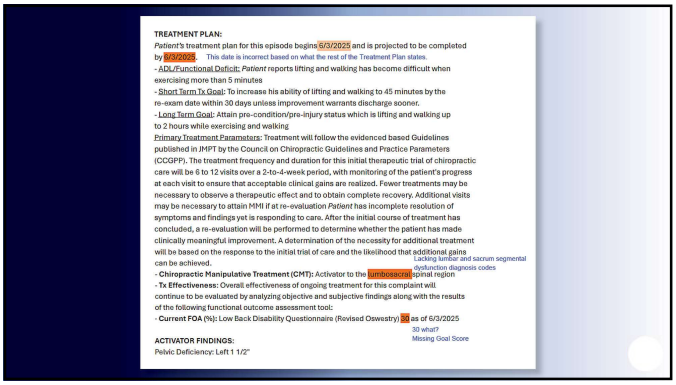
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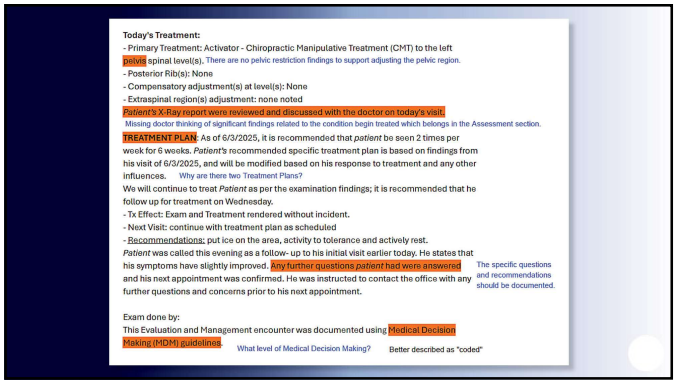
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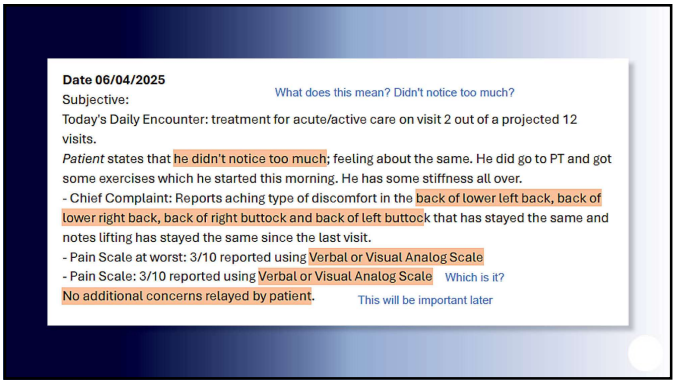
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Objective:
Upon examining *Patient* today, the following tissue and/or muscle changes were found:
In the left sacroiliac, left posterior pelvis/hip and left buttock region, pain, taut fibers, tenderness, soreness and stiffness was noted upon palpation at a moderate degree.
These findings are slightly improved compared to his last visit.
In the mid thoracic region, stiffness was noted upon palpation at a mild to moderate degree.
In the posterior cervical (neck) region, stiffness was noted upon palpation at a mild to moderate degree.
These findings are new compared to his last visit.

Why tissue only? No A or R of Part findings.

Although findings exist, there are no corresponding compliants

Patient's current condition is further complicated by the following factors which may require an increase in treatment time and frequency: older age over the age of 70 and duration of current episode longer than 1 month. The above mentioned complicating factors may result in a delay or inability for the involved dysfunctional tissue(s) to fully recover.

This language is repeated and SALTed forward from the initial and still doesn't belong here.

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Assessment:
Patient is currently in the active phase of care. *Patient* tolerated the treatment well and was adjusted today without incident.
Today it was discovered that *Patient* has responded normally since his treatment.
- Determination of Care: Continued care is necessary to meet the goal(s).

Assessment:
Patient is currently in the active phase of care. *Patient* tolerated the treatment well and was adjusted today without incident.
Today it was discovered that *Patient* has responded normally since his treatment.
- Determination of Care: Continued care is necessary to meet the goal(s).

Given visit 2, not alot of detail is necessary, plan for more how and why in future visits

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Plan:
TREATMENT PLAN:
Patient's treatment plan for this episode begins 6/3/2025 and is projected to be completed by 6/3/2025.
- ADL/Functional Deficit: *Patient* reports lifting and walking has become difficult when exercising more than 5 minutes
- Short Term Tx Goal: To increase his ability of lifting and walking to 45 minutes by the re-exam date within 30 days unless improvement warrants discharge sooner.
- Long Term Goal: Attain pre-condition/pre-injury status which is lifting and walking up to 2 hours while exercising and walking
- Chiropractic Manipulative Treatment (CMT): Activator to the lumbosacral spinal region
ACTIVATOR FINDINGS:
Pelvic Deficiency: Left 1 1/4"

All of this information is extraneous and obviously copied forward from the initial visit. It really doesn't serve a purpose here.

Today's Treatment:
- Primary Treatment: Activator - Chiropractic Manipulative Treatment (CMT) to the left pelvis, left T4 and left C6 spinal level(s).
- Posterior Rib(s): None
- Compensatory adjustment(s) at level(s): None
- Extraspinal region(s) adjustment: none noted
Patient is being seen for active care.

98941-AT was billed in error. Thoracic and Cervical spinal levels do not follow a complaint or have a functional deficit connected.

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Anatomy of an EOB

The Explanations of Benefits (EOBs) contains vital information about how a patient's claim was processed and paid. This information is used to post payments into your billing software and determine what remaining portion needs to be collected from the patient. It is important that you understand how to interpret the information on an EOB. The terminology and format may differ slightly from one insurance company to the next, but with practice, they will become easier to read.

Grange Insurance
Grange Insurance
P. O. Box 1642
Chicago, IL 60618

1 Date: 01/03/2018
1 TIN: 00-0000000
2 Benefit Plan: Local Union 222
3 EFT: 12344321

Explanation of Benefits

4 Control Number: Y6422234
5 Patient: John Doe
6 ID: TU222-86417
6 Member: Jane Doe
7 Patient Account: 1004
7 Provider: Mary Smith, DC

10 DATE(S) OF SERVICE	11 SERVICE	11 POS	12 AMOUNT BILLED	13 AMOUNT ALLOWED	14 PROVIDER DISCOUNT	15 DEDUCT/ CO-PAY	16 CO-INS.	17 PAID TO PROVIDER	18 PATIENT RESP.	19 REMARK CODE
12/01/2017	98941	11	55.00	37.00	18.00	15.00		22.00	15.00	P0
12/01/2017	97140	11	40.00	0.00				0.00	0	15
12/01/2017	97012	11	25.00	25.00	0.00		5.00	20.00	5.00	
12/01/2017	97110	11	40.00	35.00	5.00		7.00	28.00	7.00	P0

20 Total Paid to Provider: $70.00
Total Patient Responsibility: $27.00

Remark Codes 21
P0 - This provider is in the All Better network. Contractual provider discount has been applied.

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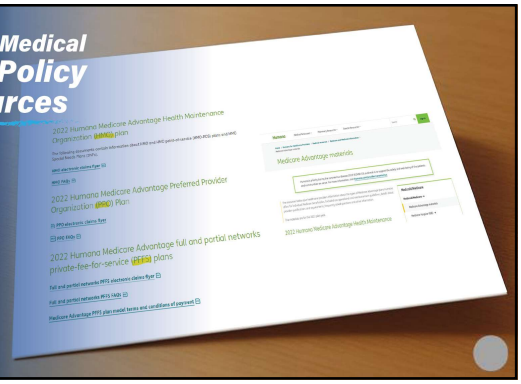
Resources to Use When Self-Auditing

- *Payer Medical Review Policies (MRPs)*
- *CMS documentation and coding articles and resources*
- *State board minimum documentation requirements*



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Check the Medical Review Policy & Resources



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Medicare Benefit Policy Manual

Chapter 15 - Covered Medical and Other Health Services

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(Rev. 12599; Issued: 05-02-24)
(Rev. 12600; Issued: 05-02-24)
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(Rev. 12865; Issued: 10-04-24)

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240 - Chiropractic Services - General
240.1 - Coverage of Chiropractic Services
240.1.1 - Manual Manipulation
240.1.2 - Subluxation May Be Demonstrated by X-Ray or Physician's Exam
240.1.3 - Necessity for Treatment
240.1.4 – Location of Subluxation
240.1.5 - Treatment Parameters

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240 - Chiropractic Services - General
(Rev. 1, 10-01-03)
B3-2250, B3-4118

The term "physician" under Part B includes a chiropractor who meets the specified qualifying requirements set forth in §30.5 but only for treatment by means of manual manipulation of the spine to correct a subluxation.

Effective for claims with dates of services on or after January 1, 2000, an x-ray is not required to demonstrate the subluxation.

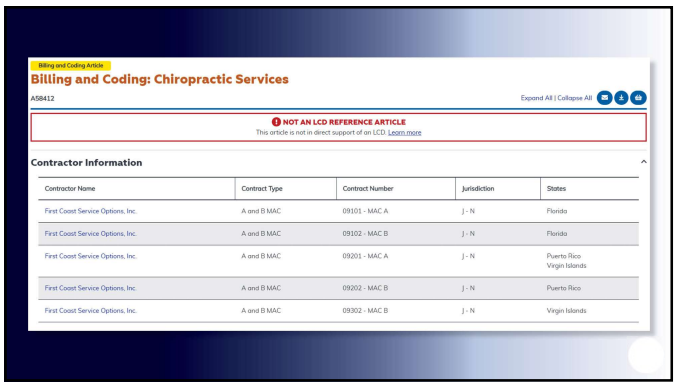
Implementation of the chiropractic benefit requires an appreciation of the differences between chiropractic theory and experience and traditional medicine due to fundamental differences regarding etiology and theories of the pathogenesis of disease. Judgments about the reasonableness of chiropractic treatment must be based on the application of chiropractic principles. So that Medicare beneficiaries receive equitable adjudication of claims based on such principles and are not deprived of the benefits intended by the law, carriers may use chiropractic consultation in carrier review of Medicare chiropractic claims.

Payment is based on the physician fee schedule and made to the beneficiary or, on assignment, to the chiropractor.

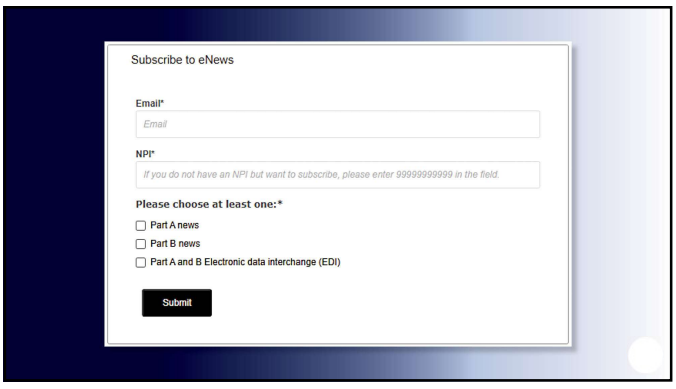
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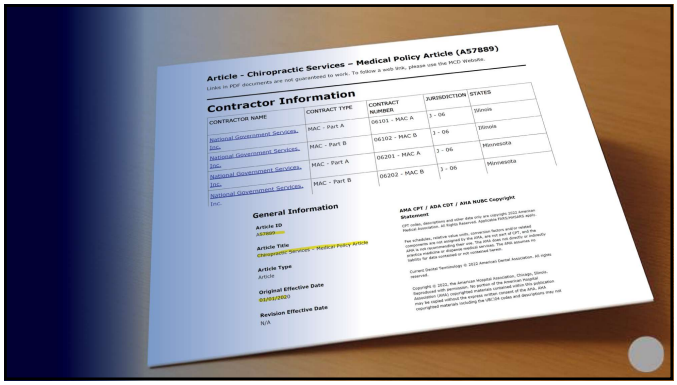
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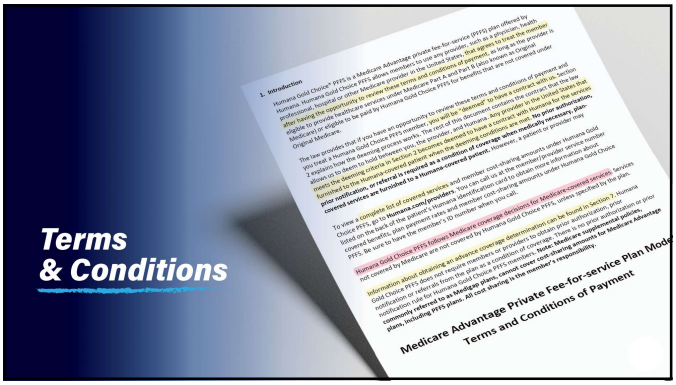
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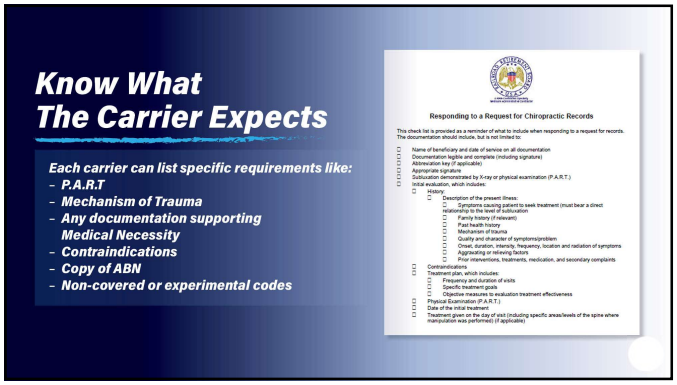
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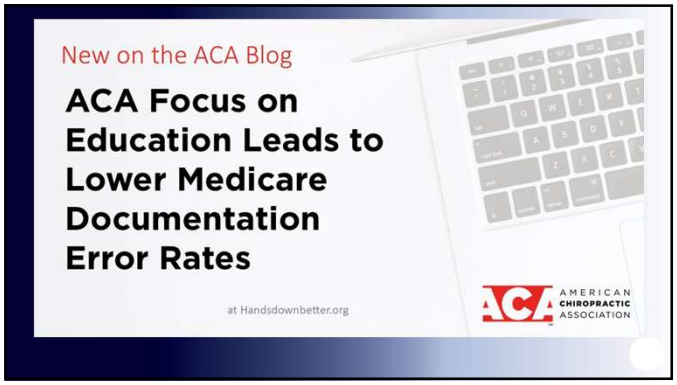
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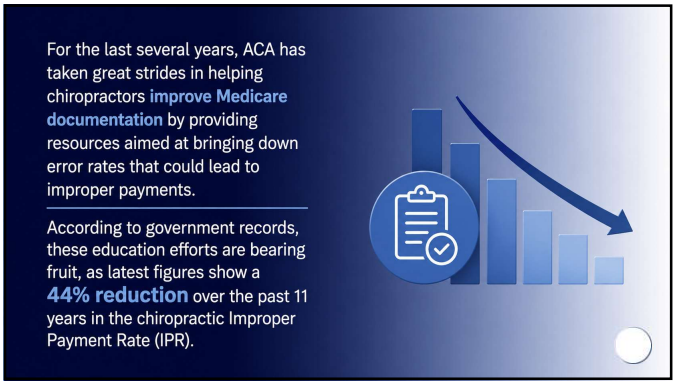
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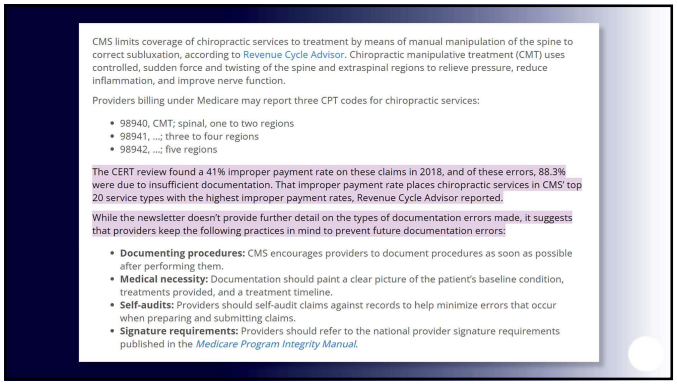
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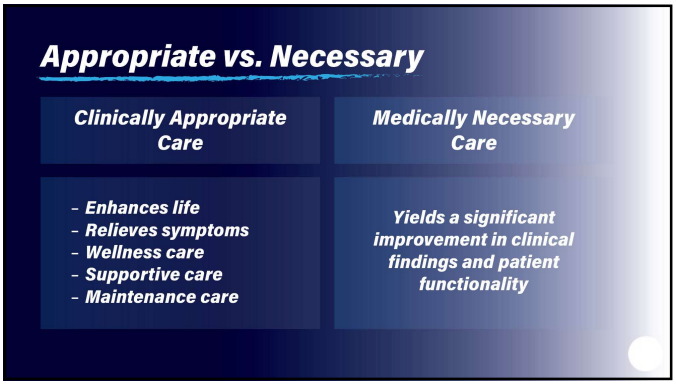
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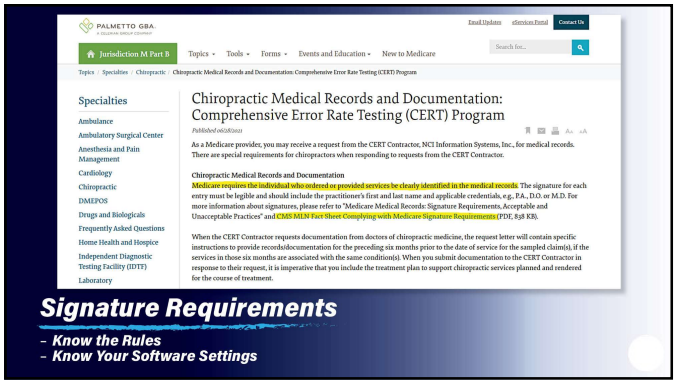
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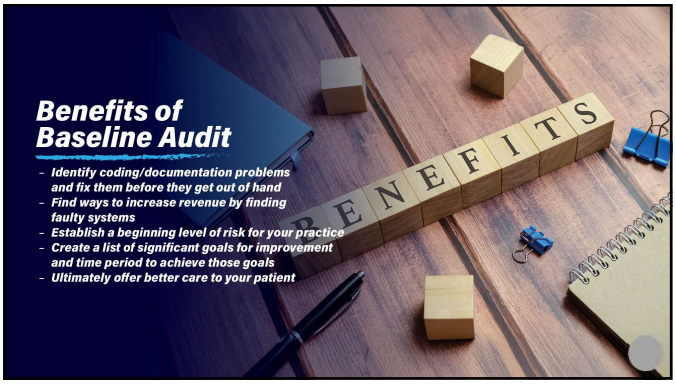
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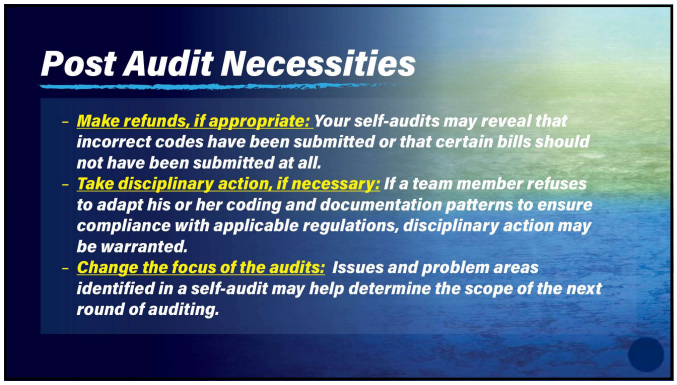
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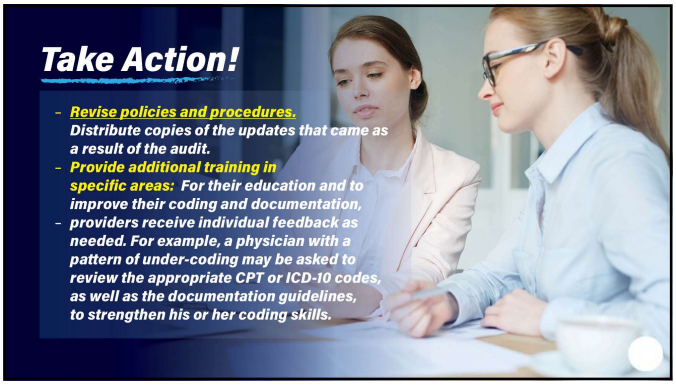
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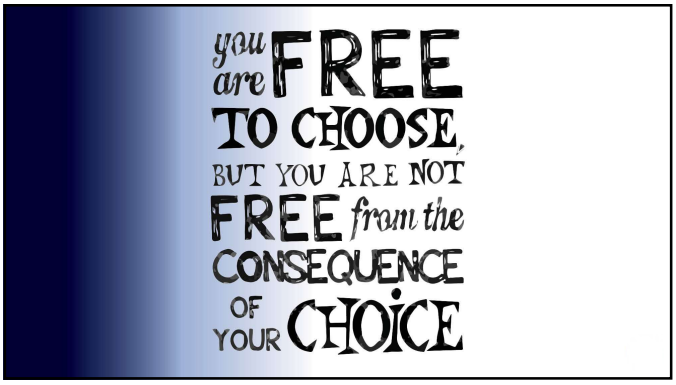
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