#6 - Developing Open Lines of Communication

- “Open Door” policy
- Bulletin Board in Common Area
- Emails
- Hotlines
- Newsletters
- Staff Meetings
Developing Open Lines of Communication

- Require employees to report conduct that a reasonable person would, in good faith, believe to be erroneous or fraudulent.
  - User Friendly Process to report erroneous or fraudulent conduct
  - S&P that states that failure to report fraudulent or erroneous conduct is a violation of the compliance program
Developing Open Lines of Communication

- If billing service is used develop a clear S&P for communication to/from service with compliance officer and compliance contact
- Utilization of process that maintains the anonymity of the reporting person (if able)
- Provisions in the S&P that reporting person will not receive retribution for reporting conduct or violations
Developing Open Lines of Communication

- If anonymity is possible for reporting person there should also be a clear standards and practice that reveal the possibility that the reporting person may need to be revealed in the event a violation produces a corrective action that results in reporting to governing authorities or law enforcement.
#7 - Enforcing Disciplinary Standards through well-publicized guidelines

- Ensure employees understand consequences of non-compliant behavior
- Standards & Practice to enforce disciplinary action
- Consistent and appropriate discipline including possibility of termination
- Flexible to allow for mitigating or aggravating circumstances
Enforcing Disciplinary Standards through well-publicized guidelines

- Disciplinary Action could include:
  - Oral or written warnings
  - Written reprimands
  - Probation
  - Demotion
  - Temporary suspension
  - Termination
  - Restitution of damages
  - Referral for criminal prosecution
Enforcing Disciplinary Standards through well-publicized guidelines

- Well-publicized guidelines
  - In house Procedure and Training Manual “Compliance Manual”
  - Changes to include Education and Training of employees
  - Use Open Communication conduits
    - Email
    - Bulletin Boards
    - Newsletter
    - Staff Meetings
Employee discipline

- Publicize and enforce policy for improper behavior and noncompliance with the practice compliance plan.
- Remedial actions may range from admonition to grounds for termination.
- Discipline consistently throughout all levels of the office staff.
- Investigate all reported and suspected improper employee behavior.
- Act promptly.
- Log all employee discipline and file this in the employees personnel file (separate from compliance manual).
#8 Employing due diligence in hiring of personnel and delegation of authority

- Screen all employees for possible propensities to engage in illegal activities.
- Special note for employees in authority
- Compliance Officer must be determined to be competent and honest
- Follow through on calling references supplied by applicant and document the outcome.
- Keep written staff meeting notes
Employing due diligence in hiring of personnel and delegation of authority

Human Resource File should include:

- Application and resume
- Any formally known as name(s)
- An I-9 form with properly verified documentation
- Social Security Number
- W-4 Form
- Copy of Identification
- References provided both professional & personal
- Documentation of reference follow up
Employing due diligence in hiring of personnel and delegation of authority

Human Resource File should include:
- Acknowledgment of Employee Handbook / policies
- Acknowledgment of Sexual Harassment Policy
- Acknowledgment in initial Compliance Training
- Acknowledgment in initial HIPAA training

- If a licensed provider
  - Copy of valid state license and explanation of disciplinary action if any on record
  - Copies of Provider Enrollment & Credentialing letters from carriers contracted
  - Any other acknowledgments, e.g. radiology manual review and signature
  - Current and Past Malpractice Insurance Declaration Pages
  - Copies of CEU Certificates and/or proof of attendance
  - Non-compete / employment contract copies, if applicable
Employing due diligence in hiring of personnel and delegation of authority

Human Resource File should include:

- Disciplinary actions
- Reviews, warnings, etc
- Track any criminal convictions

Records for all employees that work or have worked in your facility should be maintained.
Perform CORI checks on potential employees

Criminal Offender Record Information

- Access the web to download and apply for CORI certification for the facility and for those that require access to the CORI records

- CORI Records are not maintained within the Human Resource File

- Reference to the CORI Record should be within the HR File
Criminal History Systems Board

Website: www.mass.gov/chsb

- Download the CORI certification application

- Download additional Individual Agreement of Non-Disclosure & Statement of CORI Certified Compliance Forms; for any additional personal requiring CORI access

- Download the Model CORI Policy
  - Customize and adopt in your Compliance Manual
Posted Material Requirements

- Federal / State Posters posted in conspicuous area
- Workers Compensation Notice posted
- Clear Employee Policies and Conduct
- Violation and Complaint submission forms & policy
- Information on Unemployment Benefits
National Safety Compliance, Inc

1-877-922-7233
www.osha-safety-training.net

Item # P9FED $10.95
Employment Handbook / Policies

Include your facility’s compliance for the following:

- Anti-discrimination Policy
- Equal Employment Opportunity
- Uniformed Services Employment & Reemployment
- Immigration Law Compliance
- Americans with Disabilities Act (ADA)
- Family & Medical Leave Act
- Cultural Compliance

*Simply put, your entire staff plays by and follows all the rules of practice regarding Medicare, all insurances, patient privacy and safety.*
Updated W-4 Form available free

The Internal Revenue website:
www.IRS.gov
Specific URL:
I-9 Form available free

Bureau of Citizenship and Immigration Services website:
http://uscis.gov

Specific URL:
Notice to Employees (Work Comp)

- This Notice should be included with your policy renewal each year.
Compliance Plan should provide (Quality Assurance)

- Full internal assessment of all reports of detected violations
  - Ensure Compliance Officer’s follow up of all reports
  - All reports documented to and end result
  - Any allegations found to be false
  - Corrective actions taken
  - Any Standards and Practice changes resulting from violation
Compliance Plan should provide (Quality Assurance)

- Corrective Action Steps and Education and Training to prevent repeat of violation
- Review of Standards & Practice monitoring and warning indicators of violation was not detected by S&P
- Changes to Monitoring and Warning indicators in Standards & Practices
A Compliance Plan should thread into the fabric of your daily operations

The Board of examiners is much more interested in seeing an actively used compliance program, that is of modest size than a large elaborate compliance program that is rarely if ever used.
FACILITY STANDARDS

1. Chiropractic treatment may only be delivered at a chiropractic facility.
2. Licenses required for each facility.
3. Exceptions (solo practice, other state license, and limited offsite services).

Required displays.
4. Each facility must have a chiropractor of record.
5. Each facility must maintain a record of all its employees.
6. Patient records retention requirements.

Compliance plan: If a multiple disciplinary practice such as chiropractic, physical therapy and massage therapy, the compliance plan should address each department.
7. Physical conditions.
8. Transfer of ownership.
9. Change in location.
10. Owners of good moral character.
11. Insurance requirements such as malpractice and liability.
DISPLAY ALL LICENSES:

- Facility license.
- Chiropractic license of all providers.
- Physical therapy license of all providers,
- Physical therapy assistant licenses of all providers
- Massage therapy licenses.
- Sales Tax Certificate
DUTIES OF THE CHIROPRACTOR OF PATIENT RECORDS.

- Must be maintained in a safe and secure manner.
- Must be maintained for a minimum of 7 years or until the patient reaches age 9.
- Must maintain all active patient files on-site at chiropractic facility for at least 3 years.
- Must know where all records are stored: and if moved off-site location, must notify The Board & Medicare
- Must have a system of weekly backup for all electronic records held at a secure off-site location.
- Must have backup software to read the records and have the records.
- Keep a copy of all your advertising.
WARNING!

Do Not Remove Patient Records From The Office
WHERE CAN I GET MORE INFORMATION ON DEVELOPING A COMPLIANCE PROGRAM?

Additional information:

  - www.HHS.gov.oig.
- Healthcare Compliance Association (HCCA):  
- Physician practice management and billing companies.
- Law firms that specialize in healthcare issues.
- Network with doctors who have compliance plans.
MEDICARE COVERAGE FOR CHIROPRACTIC SERVICES

- Medicare covers and pays for manual manipulation of the spine only. Manual manipulation is by use of hands or handheld adjusting instrument for a neuromusculoskeletal condition, which is medically necessary and has a direct therapeutic benefit to the patient's condition and can provide a reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine demonstrated by x-ray, MRI, CT scan or physical examination. Handheld devices being controlled manually for performing manual manipulation of the spine can be used.

- All other services performed by a chiropractic physician are considered noncovered services. For example: examinations, physiotherapy, nutritional support, etc. In addition, no other diagnostic or therapeutic services furnished by a chiropractor or under his or her order is covered: for example: X-rays, MRI, CT scan, bone scan, laboratory tests, etc.
ORDERING VS. REFERRED SERVICES

1. Ordering Physician
   A physician who orders non-physician services for the patient such as diagnostic tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.

2. Referring Physician
   A physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Note: Medicare does not pay for x-rays, or other diagnostic or therapeutic services, ordered by a chiropractor. However, a chiropractor may refer their patients to a physician, such as a medical doctor or a doctor of osteopathy, for these types of services and Medicare will pay for these services providing the following is met.

The physician, medical doctor/osteopath determines that an x-ray or other diagnostic test is appropriate for the patient and assumes responsibility for ordering the test.
MEDIHCARE GUIDELINES FOR NECESSITY FOR CHIROPRACTIC TREATMENT

- The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment.
- Spinal manipulation must have a direct therapeutic relationship to the patient's condition.
- Spinal manipulation must provide reasonable expectation of recovery or improvement of function.
- The patient must have a subluxation of the spine as demonstrated by an x-ray, MRI, CT scan or physical examination.
CONDITIONS THAT MEDICARE COVERS

1. **Acute Subluxation**
   A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical examination.
   The result of chiropractic manipulation is expected to be an improvement in, arrest or retardation of the patient's condition.

2. **Chronic Subluxation**
   A patient's condition is considered chronic when it is not expected to completely resolve, but where the continued therapy can be expected to result in some functional improvement (as is the case with an acute condition).
   Once the functional status has remained stable for a given condition, further manipulative treatment is considered maintenance therapy and is not covered.

3. **Acute Exacerbation**
   Temporary marked deterioration of the patient's condition due to an acute flare-up of the condition being treated. Note: This must be documented in the patient's clinical record, including the date of occurrence, nature of the onset, or other pertinent factors that will support the medical necessity of treatments for this condition.
MEDICARE DOES NOT COVER MAINTENANCE CARE

a) Treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life is not covered.

b) A therapy that is performed to maintain or prevent deterioration of a chronic condition is not covered.

c) Once the maximum therapeutic benefit has been achieved for a given condition, ongoing maintenance therapy is not considered to be medically necessary and is not covered.

d) Continued, repetitive treatment without an achievable and clearly defined goal is considered maintenance therapy and is not covered.
1. Definition of a Subluxation:
   A motion segment, in which alignment, movement, integrity and or physiological function of the spine are altered, although contact between joint surfaces remains intact.

2. Subluxation May Be Documented by an X-ray or Physical Examination:
   Documentation by an x-ray must meet all regulations:
ACUTE CONDITIONS

- X-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific x-ray evidence is warranted.

- X-ray is considered reasonably proximate if it was taken no more than 12 months prior to or 3 months following, the initiation of a course of chiropractic treatment.
CHRONIC CONDITIONS

- If the patient's medical record indicates the condition existed longer than 12 months prior to the first treatment and the condition is considered chronic or permanent, then the x-rays must've been taken no more than 5 years prior to the current services.

- If treatment was suspended for a year or more and the medical condition is considered chronic, then the x-rays must've been taken no more than 3 years prior to the current services.
EXACERBATIONS

If an exacerbation of a medical condition occurs, then the x-rays must have been taken within 5 years of the initial treatment.
OBJECTIVE PORTION OF THE PROGRESS NOTE SHOULD BE DOCUMENTED USING THE P. A. R. T. SYSTEM

● P -- Pain/tenderness: Evaluated in terms of location, quality and intensity. This can be identified through observation, percussion, palpation, provocation etc. In addition, pain intensity may be assessed using one or the following. For example; visual analogue scale, algometers, pain questionnaires, etc.

● A -- Asymmetry/misalignment: Evaluated on a sectional or segmental level through static palpation, diagnostic imaging and observation. For example; posture and gait analysis.

● R -- Range of motion abnormality: Evaluated in changes of active, passive and accessory joint movements, which may result in an increase or decrease in sectional or segmental mobility. In addition, ROM abnormalities may be identified by one or more of the following. For example; upon palpation, observation, stress diagnostic imaging, range of motion measurements, etc.

● T -- Tissue, tone, texture or temperature abnormality: Evaluated by changes in the characteristics of contiguous or associated soft tissues, which include skin fascia, muscles and ligaments. This may be identified by one or more of the following. For example; observation, palpation, use of instrumentation, etc.
1. **Patient history, which should include the following:**
   - Symptoms causing the patient to seek treatment (chief complaint).
   - Onset, duration, intensity, frequency, location and radiation of symptoms.
   - Quality and character of symptoms and problems.
   - Aggravating and/or relieving factors.
   - Mechanism of trauma.
   - Family history if relevant.
   - Past history, including general health, prior illnesses, injuries, surgery, hospitalizations and medications.
   - Prior interventions, treatments, medications, secondary complaints.
MEDICARE DOCUMENTATION
REQUIREMENTS FOR INITIAL VISIT

2. Description of present illness, which should include the following:

- Patient’s symptoms must bare a direct relationship to the level of subluxation.
- The symptoms should refer to the spine, muscle, bone, rib and joint and be reported as swelling, spasm, etc.
- Vertebral pinching of spinal nerves may cause headaches, arm, shoulder and hand problems, as well as leg and foot pains and numbness.
- Rib and rib chest pains are also recognized symptoms, but in general other symptoms must relate to the spine.
- The subluxation must be the causal (the symptoms must be related to the level of the subluxation that has been identified).
- The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.
3. Evaluation of the neuromuscular system through physical examination. Diagnosis, which should include the following:

4. The primary diagnosis must be subluxation including the level. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named. (listings)

5. Treatment plan, which include the following: Recommended level of care (duration and frequency of visits). Specific treatment goals. Objective measures to evaluate treatment effectiveness.

6. Date of the initial treatment
MEDICARE DOCUMENTATION REQUIRED FOR SUBSEQUENT VISITS REGARDLESS IF THE SUBLUXATION IS DEMONSTRATED BY AN X-RAY OR BY PHYSICAL EXAMINATIONS:

1. **History, which include the following:**
   - Review of chief complaint.
   - Changes since last visit.
   - System review, if relevant.

2. **Physical exam, which include the following:**
   - Exam of area involved in diagnosis.
   - Assessment of how the patient condition changed since the last visit.
   - Evaluation of treatment effectiveness.

3. **Documentation of treatment given on day of visit.**
PROGRESS NOTES AFTER INITIAL VISIT SHOULD ALWAYS BE IN THE SOAP FORMAT:

1. **S-- Subjective complaint, which include the following:**
   Document how the patient is feeling. This should include location of pain, quality, level of function (ADL), condition better, worse or the same. Severity of pain, (qualified by using pain analogue scale, 0-10, zero -- no pain, 10-- severe pain).
   In addition, outcome assessment questionnaires should be utilized to further document care.

2. **O-- Objective findings, which include the following:**
   Document visual observation (inspection), physical examination findings such as static and motion palpation, which includes muscle spasm/tightness, tenderness, trigger points and range of motion. Document orthopedic and neurologic testing, laboratory studies and diagnostic imaging such as x-ray findings, MRI, CT scan, bone scan etc. Document objective portions of soap notes as per the P. A. R. T. system.
PROGRESS NOTES AFTER INITIAL VISIT SHOULD ALWAYS BE IN THE SOAP FORMAT:

3. **A-- Assessment, which include the following:**
   Diagnostic impressions, short and long-term goals and expected functional outcomes. In addition, the doctor should evaluate the overall progress the patient is making to their treatment plan.

4. **P-- Plan, which include the following:**
   Document treatment received and frequency that the patient will be seen. Document what procedure was performed on the patient that day, exactly where on the body the treatment was rendered, what settings were used if PT was involved, how long it was done, what dosages and frequency were used. Document any patient instructions such as home care (ice/heat, belts/collars, exercises, work/home restrictions etc.).
   You can indicate patient tolerated procedures well, if in fact, they did. If any complications, do not ignore them. Describe the problem and indicate what instructions were given to the patient to remedy their situation.
   In addition, a brief post assessment of that day's treatment should be performed, which is intended to evaluate the patient’s response to their treatment that day.
   Always date progress notes and be as specific as possible when documenting medical information.
   Sign or initial soap notes when completed.
DOCUMENT YOUR PHONE CALLS:

- Document to or from a patient with date, time and substance of call or recommendations given.
- For example, Sally Mae DOB: 11/3/36, date of phone call 3/20/06.
- Sally Mae called this morning requesting an emergency call back. I called Sally Mae at 10:20 a.m. on 3/20/06 and she described she's been having acute left chest and left mid-back pain since yesterday without apparent trauma. She said she had been feeling much better since her last adjustment and had not required Motrin, even for the past 2 days until this pain developed. She said there's no problem taking a deep breath or with breathing, but she's uncertain as to what's going on.
- I recommend that Sally Mae call her cardiologist immediately and get an evaluation and if the cardiology checks out fine for her to come into the office here later today. Sally Mae understood my concern and said that she will immediately call Dr. Soly.
SPECIFIC CMT CODES FOR CHIROPRACTIC MANIPULATIVE TREATMENT:

- **98940** - Spinal manipulation 1-2 regions.
- **98941** - Spinal manipulation 3-4 regions.
- **98942** - Spinal manipulation 5 regions.
- **98943** - Extra spinal 1 or more regions.
SPECIFIC CMT CODE DESCRIPTORS:

NOTE: These codes are based upon the number of body regions receiving manipulation.

**Cervical spine**-Includes atlanto-occipital joint and C1-C7.

2. **Thoracic spine**-Includes T1-T12 and posterior ribs (costotransverse and costovertebral junction).

**Lumbar spine**-Includes L1-L5.

**Sacral**-Includes sacrum and sacral coccygeal junction.

**Pelvic**-Includes sacroiliac joint and other pelvic articulations.

**Extra spinal**-Which are further broken down as follows:

a. **Head**-Includes head and TMJ

b. **Lower extremities**-Includes hip, knee, leg, ankle and foot.

c. **Upper extremities**-Includes shoulder, arm, elbow, wrist and hand.

d. **Rib cage**-Includes anterior rib cage and costosternal junction.

e. **Abdomen**
Note: A minimum of 2 diagnoses are required on every Medicare claim.

1. The primary diagnosis is indicating the precise level of M99.01, M99.02, M99.03 subluxation, must be listed first. For example: M99.04, M99.05 If the claim does not have one of the primary diagnoses, the claim will be denied as not medically necessary.

2. The secondary diagnosis (neuromusculoskeletal condition/medical diagnosis) must be listed second. If the claim does not have the secondary diagnosis code listed, as per Medicare policy, the claim will be denied.

Note: Refer to AMA ICD-10-CM 2017 “The Complete Official Code Book” for appropriate codes.
Make up a Medicare Event Form

- This form would have a small pain drawing and VAS scale as well as space to briefly describe the patient’s complaint.

- Used in new injury, illness, or surgery.
DETERMINING WHEN DIAGNOSTIC TESTING IS APPROPRIATE:

Diagnostic procedure should only be considered after a complete medical history and complete physical examination was performed and the physician determines that the diagnostic testing would be medically necessary in order to further evaluate the patient's medical disorder as well as significantly affect the patient's treatment protocol.
COMMONLY USED DIAGNOSTIC PROCEDURES IN CHIROPRACTIC PRACTICE:

Plain film x-rays - The most widely utilized skeletal imaging method. Primarily used to rule out fractures, dislocations, anomalies or bone pathology as well as used in biomechanical analysis. The doctor should take into account some of the following guidelines for performing skeletal radiographs.
COMMONLY USED DIAGNOSTIC PROCEDURES IN CHIROPRACTIC PRACTICE: Plain film x-rays-

- **Probable indicators:**
  - Trauma-Both recent and old.
  - Assessment of joint instability.
  - Unexplained weight loss.
  - Night pain.
  - Neuromotor deficit.
  - Inflammatory arthritis.
  - History of malignancy.
  - Fever of unknown origin greater than 100°F.
  - Abnormal blood findings.
  - Deformity: for example: scoliosis.
  - Failure to respond to therapy.
  - Medical legal implications.
COMMONLY USED DIAGNOSTIC PROCEDURES IN CHIROPRACTIC PRACTICE: Plain film x-rays-

- Possible indicators:
  - The greater than 50 years old.
  - Drug or alcohol abuse.
  - Corticosteroid use.
  - Unavailability of alternate imaging.
  - Unavailable, loss, outdated or non-diagnostic previous x-ray studies.
  - Research.
  - Systemic disease.
COMMONLY USED DIAGNOSTIC PROCEDURES IN CHIROPRACTIC PRACTICE: Plain film x-rays-

- Non-indicators to take plain film x-rays:
  - Patient education.
  - Routine screening.
  - Habit.
  - Discharge status assessment.
  - Routine by a mechanical analysis.
  - Pre-employment examination.
  - Physical limitations of patient.
  - Financial gain.
  - Patient recently exposed high levels of radiation exposure.
  - Pregnancy.
THINGS TO CONSIDER WHEN INTERPRETING PLAIN FILM X-RAYS OF THE SPINE AND/OR EXTREMITIES:

- Always have access to the appropriate clinical information: for example: patient intake form, case history, past medical history, family history and physical examination findings.
- Identify the x-ray views taken, always have opposing views available and be certain films are of high quality.
- Do a quick scan first and give your initial impression: for example: normal/abnormal, congenital/acquired.
- Identify and evaluate alignment and all bony structures.
- Identify and evaluate all areas of cartilage (joint spaces).
- Identify and evaluate all soft tissue structures.
THINGS TO CONSIDER WHEN INTERPRETING PLAIN FILM X-RAYS OF THE SPINE AND/OR EXTREMITIES:

- Always try to obtain any prior films for comparison.

- When done reviewing films it's good to stop and come back a few hours later to review films again. This acts as a safety feature to double-check yourself. Looking at the films, 1 week after beginning treatment with the patient is also often a good idea.

- Indicate x-ray findings and record and radiographic diagnosis if known.

- Refer out for additional diagnostic studies, and/or laboratory tests if clinically and medically necessary in order to further evaluate and make the proper diagnosis.

- Also keep in mind the 5 radiographic densities: for example: air, fat, water, bone and metal. In addition, it's very important that you know what normal anatomy is in order to detect abnormal anatomy.

- Remember you're held responsible for whatever findings are on the film.
IMPORTANT CLINICAL LABORATORY TESTS AID IN THE DIFFERENTIAL DIAGNOSIS OF MUSCULOSKELETAL DISORDERS:

Blood chemistry panels, CBC and UA scan a number of different diseases. Abnormalities do not always necessarily mean the patient has a disease and some patients with diseases may have normal test results.

The different panels and tests listed, which can be performed on a patient (if clinically indicated) may give clues to assist in the differential diagnosis of musculoskeletal disorders.

In addition, the different panels and tests listed are addressing some of the common findings with these tests and does not represent an all-inclusive list of abnormal findings.

Keep in mind, there are many variations that can alter the results of these tests and abnormal findings should not be a cause for alarm, but should raise the possibility of a red flag for the chiropractic physician to further evaluate and/or reassess the patient.
Primarily used to detect skeletal metastasis, tumors, infections, arthritis, fractures (occult, stress and recent fractures), and avascular necrosis. Done by injecting a radioisotope intravenously and waiting various time periods to record areas of increased uptake (hotspots). In addition, there are other areas that can be evaluated: for example: brain, heart, lung and kidneys.
COMMONLY USED DIAGNOSTIC PROCEDURES IN CHIROPRACTIC PRACTICE: Tomography

Primarily used to obtain specific images of anatomy and its abnormalities that are not accessible by plain film x-rays. It also enables the physician to obtain specific images of selected levels in the body by blurring out all structures above and below the selected level in question.
COMMONLY USED DIAGNOSTIC PROCEDURES IN CHIROPRACTIC PRACTICE:
SPECT (Single Photon Emission Computed Tomography)

Is a SPECT combination tomography and bone scan. Primarily used to evaluate areas within bone or areas where bone overlap: for example: Pars interarticularis and/or spondylolisthesis.
COMMONLY USED DIAGNOSTIC PROCEDURES IN CHIROPRACTIC PRACTICE: Myelograms

Primarily used to diagnose discs, vertebral canal (stenosis), spinal cord and nerve root disease. Done by injecting a water-soluble contrast media into the subarachnoid space.
COMMONLY USED DIAGNOSTIC PROCEDURES IN CHIROPRACTIC PRACTICE: Discography

Primarily used to evaluate disc pathology: for example: degeneration, disc architecture, pain response and disc resistance to injection. Done by injecting a water-soluble contrast media into the disc under fluoroscopic control.
COMMONLY USED DIAGNOSTIC PROCEDURES
IN CHIROPRACTIC PRACTICE: Ultrasound

Primarily used to diagnose abdominal, pelvic and vascular disease: for example: soft tissue masses (cystic or solid).
COMMONLY USED DIAGNOSTIC PROCEDURES IN CHIROPRACTIC PRACTICE: CAT SCAN

- Primarily used to evaluate the central nervous system (CNS).
- When evaluating the skeleton, it aids in detecting neoplasms, trauma, infections, metabolic disease and spinal syndromes.
COMMONLY USED DIAGNOSTIC PROCEDURES IN CHIROPRACTIC PRACTICE: Magnetic Resonance Imaging (MRI)

- Primarily used to evaluate soft tissue: for example: discs (degeneration, bulges, herniations), ligaments (tears), muscle, spinal cord (tumors), nerve roots as well as bone marrow, joints, spinal canal and/or lateral recess, intracranial disease and central nervous system disorders:

- For example: multiple sclerosis. In addition, intravenous contrast, (gadolinium) will enhance areas of increased vascularity: for example: neoplasm, inflammation and scar tissue.
COMMONLY USED DIAGNOSTIC PROCEDURES IN CHIROPRACTIC PRACTICE: Bone Density

Primarily used to measure true mass of bone, predict the risk of future fractures and monitor the effectiveness of treatment.
COMMONLY USED DIAGNOSTIC PROCEDURES IN CHIROPRACTIC PRACTICE: Paraspinal ultrasound

Used to detect muscle bleeding and inflammation.
Primarily used to evaluate sensory/neural abnormalities and myofascial irritation.
COMMONLY USED DIAGNOSTIC PROCEDURES
IN CHIROPRACTIC PRACTICE: EMG (Electro myography)

Primarily used to evaluate muscle and nerve (neural function) for example: irritation.
COMMONLY USED DIAGNOSTIC PROCEDURES IN CHIROPRACTIC PRACTICE:
Nerve Conduction Velocity (NCV)

- Primarily used to evaluate peripheral nerve injuries and diseases affecting the peripheral nervous system.

- Note: Usually performed after the first 30 days or acute period of treatment to obtain an accurate reading.
COMMONLY USED DIAGNOSTIC PROCEDURES IN CHIROPRACTIC PRACTICE:
SSEP (somatosensory evoked potential)

Primarily used to evaluate peripheral cutaneous receptors in the primary somatosensory cortex.
THINGS TO CONSIDER WHEN INTERPRETING PLAIN FILM X-RAYS OF THE SPINE AND/OR EXTREMITIES:

- It should be noted that there are many different ways to evaluate and interpret radiographic films of the spine, and there's no 1 method that is considered better than another.

- Interpretation/evaluation depends on the individual and what best suits them. What is important is that the physician uses some kind of systematic approach to evaluate all aspects of the film. With this in mind, there are some key factors that are considered important and are listed as follows:
BLOOD CHEMISTRY PANEL:

- **Glucose**: Blood sugar test to diagnose diabetes or monitor medication.
- **Uric acid**: Associated with joints (Gout) or kidney pain (stones).
- **Urea nitrogen**: Measures kidney function.
- **Creatinine**: Measures kidney function.
- **BUN**: Blood urea nitrogen byproduct of metabolism removed from blood by the kidneys.
- **BUN/creatinine ratio**: The relationship between BUN and creatinine.
- **Sodium**: Associated with kidney disease, certain adrenal diseases and dehydration.
- **Potassium**: Associated with liver damage.
- **Chloride**: Associated with kidney disease, certain adrenal diseases and dehydration.
- **Carbon Dioxide**: Gas used to maintain the pH, prevent acitic or alkaline state.
- **Calcium**: Increased in thyroid problems, decreased in poor diet, kidney disease and/or vitamin D deficiency.
- **Phosphorous**: Related to calcium, usually follows opposite pattern.
- **Total protein**: Measures blood proteins *Albumin* and *globulin* associated with liver disease.
BLOOD CHEMISTRY PANEL:

- **Albumin**: Blood protein manufactured by the liver. Associated with liver disease, poor nutrition and/or dehydration.
- **Globulin**: A blood protein similar to albumin and manufactured by the liver.
- **A/G ratio**: The relationship between albumin and globulin.
- **Bilirubin**: Aids in digestion. Increased usually associated with liver disease.
- **Alkaline phosphatase**: Enzyme in the blood if increased associated with liver or bone disease: for example: Paget's disease, malignancy (osteoblastic), hyperparathyroidism, rickets etc.
- **Lactic dehydrogenase (LDH)**: Increased associated with skeletal muscle, liver and myocardial infarction.
- **SGOT (AST)**: Increased associated with liver, skeletal muscle, kidney or red blood cells.
- **SGPT (ALT)**: Increased associated with liver disease.
- **GGT**: An enzyme used to diagnose liver and gallbladder disease.
- **Iron**: Decreased values associated with anemia and pregnancy.
- **Cholesterol**: High levels are associated with increased incidence of coronary/heart disease.
- **HDL**: Cholesterol-blood lipids, "good" fat, high levels associated with decreased risk of heart disease.
- **HDL/cholesterol ratio**: Relationship between the HDL and total cholesterol.
- **HDL risk factor**: High levels associated with increased risk of coronary heart disease.
- **LDL cholesterol**: Blood lipids "bad" fat, high levels associated with increased risk of heart disease.
- **Triglycerides**: Increased associated with diabetes mellitus, acute alcoholism, nephrotic and use of oral contraceptives.
SPECIFIC BLOOD CHEMISTRY PANELS:

- Bone panel:
- **Total protein**- See blood chemistry panel previously discussed.
- Calcium.
- **Serum protein electrophoresis**- Aids in the workup of patients with liver disease, multiple myeloma, *macroglobulinemia, hypoglobulinemia*, collagen diseases and nephrotic syndrome.
- Complete blood count (CBC).
- Ionized calcium.
- Alkaline phosphatase.
ARHTITIS PANEL:

- **RA latex** - Associated with collagen disease. For example: rheumatoid arthritis.
- **Uric acid** - Increased associated with gout, leukemia, lymphoma and chronic renal disease.
- **ANA screen** - Associated with systemic connective diseases: for example, SLE, scleroderma, rheumatoid arthritis, etc.
- **C-reactive protein (CRP)** - Associated with tissue damage.
- **HLA-B27** - Indicative of ankylosing spondylitis.
- **HLA-B8** - Approximately 40% of the time is positive, indicative of DISH (diffuse idiopathic sclerosing hypertrophy).
JOINT PAIN OR SWELLING TESTS:

- **CBC** – Complete Blood Count
- **Erythrocyte sedimentation rate (ESR)**-Associated with inflammation.
- **Synovial fluid analysis, including culture**-Assist in the detection and differential diagnosis of osteoarthritis, traumatic arthritis, pseudogout, gout, rheumatic fever, bacterial arthritis, tuberculosis arthritis and lupus erythematosus.
- **RA latex**-Associated with collagen disease: for example: rheumatoid arthritis.
- **ANA screen**-Associated with systemic connective tissue diseases: for example, SLE, scleroderma, rheumatoid arthritis, etc.
- **Uric acid** – Gouty arthritis
PROSTATE PROFILE:

Prostatic Acid Phosphatase-Increased associated with carcinoma of the prostate. Prostate specific antigen (PSA) increase associated with carcinoma of the prostate.
THYROID PROFILE

- **T3** *(TRIODOTHYROMINE)*- Increase associated with hyperthyroidism, severe liver disease, nephrosis, etc. Decrease associated with hypothyroidism and normal pregnancy.
- **T4** *(Thyroxin)*- Increase associated with hyperthyroidism, acute thyroiditis, early hepatitis and pregnancy. Decrease associated with hypothyroidism, chronic thyroiditis, nephrosis, etc.
- **Free thyroxin index (FTI)**- Increase associated with hyperthyroidism. Decrease associated with hypothyroidism.
- **Thyroid stimulating hormone (TSH)**- Markedly elevated in primary hypothyroidism.
PARATHYROID FUNCTION AND CALCIUM METABOLISM:

- Serum calcium.
- Alkaline phosphatase.
- Urine calcium - Increase associated with primary hyperparathyroidism, vitamin D toxicity, osteolytic conditions, Paget's and renal tubular acidosis, etc.
- Serum phosphorus - Increase associated with hypoparathyroidism, vitamin D toxicity, kidney disease, *acromegaly*, Cushing's disease, etc.
- Total protein
HYPERTENSION
(RISK PROFILE):

- Cholesterol.
- High-density lipoprotein (HDL)-Cholesterol.
- Coronary risk indicator.
- Triglycerides.
- Low-density lipoprotein (LDL)-cholesterol.
PANCREAS FUNCTION TESTS:

- CBC.
- **Glucose tolerance test (GTT)**- Increase associated with diabetes mellitus and decrease associated with hypoglycemia.
- **Lipase**- Increase associated with acute pancreatitis.
- **Amylase**- Increase associated with acute pancreatitis.
LIVER FUNCTION TESTS:

- **Total protein** - Albumin and globulin.
- **Bilirubin** - Total and direct.
- **Cholesterol**.
- **Serum glutamic oxaloacetic transaminase** (SGOT), a.k.a. (AST).
- **Gamma-Glutamyl transpeptidase** (GGT) or **Peptidase**.
- **Alkaline phosphatase**.
- **Serum glutamic pyruvate transaminase** (SGPT).
- **Lactic dehydrogenase** (LDH).
MISCELLANEOUS TESTS:

- **Urine (Benz-Jones protein)**- Increase associated with malignant conditions: for example: multiple myeloma.
- **Antistreptolysin-O tighter (ASO)**- Increase associated with acute rheumatic fever and acute *glomerulonephritis*.
- **Anti-nuclear antibody (ANA)**- Associated with SLE and other various connective tissue diseases.
- **CBC**:  
  - **CBC (complete blood count) with differential**:  
    - **WBC**- High count associated with infection or disease.  
    - **RBC**- Decrease is associated with anemia.  
    - **HGB**- Low levels associated with anemia.  
    - **HCT**- Low levels associated with anemia.  
    - **MCV, MCH, MCHC**- Used to aid in the diagnosis of anemia.  
    - **Neutrophils, lymphocytes, eosinophils, basophils, monocytes**- Associated with fighting infection to produce antibodies.  
    - **Platelet**- Associated with clotting mechanism.
UA (urinalysis):

- **Color** - Varies from pale yellow to dark amber usually proportional to concentration.
- **Appearance** - Normally *clear if freshly* voided.
- **Specific gravity** - Measures kidneys ability to concentrate urine.
- **PH.** - Normally more acidic.
- **Protein** - Associated with renal disease.
- **Glucose** - Associated with diabetes.
- **Ketones** - Found in fever, anorexia, GI disturbances, and starvation.
- **Blood** - Detects both intact RBC's and lyside RBC's - Associated with disease or trauma anywhere in the kidneys or urinary tract. Also, associated with prostatitis, renal carcinoma, *renal calculi* and excessive exercise like marathon runners.
- **Bilirubin** - Associated with liver disease.
- **Glucocytes** - Associated with *pyelonephritis* or inflammation involving other structures and urinary tract.
- **Casts** - Associated with renal failure.
- **Bacteria** - Associated with contamination.
Counseling-discussion with patient and/or family concerning 1 or more of the following 6 items

- Results of diagnostic tests and or recommended diagnostic studies.
- Prognosis.
- Risks and benefits of management/treatment options.
- Instructions for management/treatment and or follow-up.
- Importance of management/treatment compliance.
- Patients/family education.
Counseling-discussion with patient and/or family concerning 1 or more of the following 6 items

Coordination of care-consulting with other health-care providers.
Nature of presenting problem-refers to the reason the patient has consulted you. For example: disease, illness (sign/symptom), injury or any other reason the patient would consult you.

There are 5 types of presenting problems:
1. **Minimal presenting problem**-A problem that may not require a physician, but services provided under physician's supervision.

2. **Self-limited or minor presenting problem**-A problem that runs a definite or prescribed course, transient in nature and is not like to permanently alter health status or has a good prognosis with management compliance.

3. **Low severity presenting problem**-A problem where risk of morbidity (disease) without treatment is low, there is little to no risk of mortality (death) without treatment and full recovery without functional impairment is expected.

4. **Moderate severity presenting problem**-A problem with a risk of morbidity (disease) without treatment is moderate, there is moderate risk of mortality (death) without treatment and there is an uncertain prognosis or increased probability of prolonged functional impairment.

5. **High severity presenting problem**-A problem where the risk of morbidity (disease) without treatment is high, there is moderate to high risk of mortality (death) without treatment or there is high probability of severe, prolonged functional impairment.
Nature of presenting problem-refers to the reason the patient has consulted you. For example: disease, illness (sign/symptom), injury or any other reason the patient would consult you.

6. Amount of time estimated the physician spends with the patient:
The following slides show resources for you to consider. We do not have any financial relationship with any of the companies that offer these products, they are offered only as resources for you to start with on your path to compliance.
Available online & office supply stores

Once *trained* saves time and money
Medical, Chiropractic, Therapy, Office Managers, Billing Offices, Attorneys, and service providers to these industries are all individually represented in our membership rolls. Multidisciplinary or not, you need the information and constant updates that the Academy provides.

MAAMA is your one call source to saving time, money and staying on top of new developments in the rapidly changing medical market.

You don't have time to do it yourself and you should be concentrating on doing your job, not ours!

D & P Compliance can arrange for a professional audit of your records.
Transam Associates, Inc.

A Medical Transcription Company

Linda Loehr, President
3433 Lithia Pinecrest Road #303
Valrico FL 33594

Phone: 866.291.7650 x120
www.transamassociates.com
List the ones **you** use in daily practice in your compliance plan.
Workshop for Compliance

Compliance (Manual) Binder

- Introduction including Mission Statement
- Compliance Audit
  - Standards & Procedures
    - Current policies, protocols
    - Scheduled Audits
  - Claims Submission Audit
    - Patient Charts
    - Documentation
    - Claim Form Fields
    - Coding
    - 3rd Party Payer Policies
    - Medicare / Health Policies
Workshop for Compliance

- Develop Written Standards & Procedures
  The goal is to have written standards and procedures for every aspect of your practice to ensure quality assurance and compliance.

  Take this one step at a time to not overwhelm yourself and your staff
Workshop for Compliance

- Suggested Standards & Procedures to begin:
  - Documentation
    - E/M Services
    - Radiology Reports
    - Daily SOAP Notes
    - Discharge Summary
    - Narratives
  - Billing & Coding
    - Encounter Forms (daily reporting of services)
    - Data Entry of services and patient information
    - Claim Form Completion
Workshop for Compliance

- Billing and Coding
  - Posting of payments
  - Refunding when necessary
- Usage of Therapies & Modalities
- Referrals to outside providers
- Referrals for further diagnostic testing
- Medicare Documentation
- Auditing Procedures
- Facility postings and signage
Workshop for Compliance

- Compliance Officer
  - Assignment of Compliance Officer
  - Assignment of Compliance Contact, if applicable
  - Outline of responsibilities and duties
  - Compliance Committee
Workshop for Compliance

- Education & Training
  - Compliance Training
  - New Hire Training
  - Standards and Procedures
  - Reporting of suspected violations
Workshop for Compliance

- Responding appropriately to detected offenses and developing corrective action.
  - Documenting suspected violations
  - Documenting investigations
  - Documenting Corrective Actions Steps and trainings
  - Documenting disciplinary actions, if applicable
Workshop for Compliance

- Developing open lines of communication
  - Staff Meetings
  - Bulletin Boards
  - Newsletters
  - Education and Training Sessions
Workshop for Compliance

- Enforcing disciplinary standards through well-publicized guidelines.
  - Ensure staff review of compliance manual
    - Standards and Procedures
    - Consequences of not reporting suspected violations
Workshop for Compliance

- Due diligence in hiring
  - Follow up on Business and Personal References
  - CORI Checks
  - BoR Website review of license status
  - Complete HR file (partial list)
    - Resume or application
    - I-9 & W-4
    - SS# and Date of Birth
    - Credentialing Welcome Letters
Helpful Hints

- Develop a schedule and deadlines for completion
- Don’t overwhelm yourself by tackling too much at once
  - Baby Steps
- Delegate to your most organized staff members
- Collaborate with your peers
Quality Assurance

- A well organized and implemented plan will immensely improve your practice
- Improve employee performance and morale
- Improve insurance reimbursement and desk collections
- Easier and more efficient training of new hires
- Reducing risk of malpractice and Board Complaints
- Reduce risk of insurance denials
References

Federal Register/volume. 65, #194/Thursday, October 5, 2000/notices.
Department of Health and Human Services Office of Inspector General.

OIG compliance program for individual and small-group physician practices.
Agency: Office of Inspector General (OIG, HHS)

ChBoR Record Keeping Seminar
November 2005


AMA ICD-10-CM 2017 The Complete Official Code Book

Current Medicare Local Coverage Determination

References:

1. ACA Chiropractic Coding Solutions Manual 2000
2. ACA Today November 2005
5. Bergman, Peterson and Lawrence; Chiropractic Technique, Churchill Livingstone 1993
7. CMS Medicare Manual 5/28/04, New Requirements for Chiropractic Billing of Active Corrective Treatment and Maintenance Therapy
8. CMS 12/8/05, New Policy Changes/Coding Guidelines
11. Evans, Illustrated Essentials In Orthopedic Physical Assessment, Mosby Inc 1994
15. Journal of The American Chiropractic Association, article Malpractice Without Consent: Care and Record Keeping, You Could Lose It All, September 1999
16. Macklai, Clinical Imaging, Mosby, Inc 1999
18. NDCDA (National Chiropractic Council for Quality Assurance) Guidelines

Courtesy of www.chirocredit.com