Dynamic Chiropractic

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Insider Secrets About Recovery or Postpayment Audits

Tom Necela, DC

In June 2009, I had the privilege of attaining certified professional medical auditor (CPMA) certification as offered by the National Alliance of Medical Auditing Specialists. In a nutshell, I was trained to think, analyze and act in the role of a professional auditor. Admittedly, my purpose in obtaining this certification was not so that I could begin working for an insurance company or third-party entity that audits chiropractic claims and records. Instead, I sought this certification so that I could better understand what the auditors are looking for, learn the methods auditors are using to identify fraudulent or substandard practices, and then apply this knowledge toward helping chiropractors.

Interestingly enough, my attendance in the auditing certification program was met with great curiosity. The professionals who were taking the program with me were shocked to discover that I was a chiropractor and even more astonished that I was a certified professional coder as well. Most attendees were compliance professionals, billing specialists and auditors working for major hospitals, medical groups and insurance companies throughout the country. Certainly a solo practitioner of any kind would have been surprising. Apparently a chiropractor was simply unheard of. (In fact, I later confirmed that I am the first chiropractor to achieve such a certification in auditing.)

Despite the fact that many of my fellow attendees held a prejudice against chiropractors, I was able to ascertain the reasons for their bias. Some of them had audited chiropractic chart notes and were not impressed with our ability to document what we do. Others were confused or frustrated by our use of "chiropractic-specific" terminology. One billing professional even confided that she refused to take chiropractors as clients because they were too much work due to their lack of knowledge regarding standard documentation, coding and billing practices.

This provided me with interesting food for thought. If we are to successfully navigate the waters of the "postpayment audit" era as a profession, we need to really begin to understand the mindset of the auditors and other professionals who are going to be analyzing what we do. The above comments from my auditing classmates perhaps all stem from a central challenge we face: We are chiropractors who are working in the medical model and reimbursement system. Third-party reimbursements are designed not for chiropractic, but for medicine. Therefore, we need to try to utilize their language, learn how to appropriately use their coding system and diagnoses, and in general communicate in a way which they can understand.

I know this is in direct opposition to some prevailing philosophies in the profession, but the fact of the matter is that we cannot have it both ways. If you think your chiropractic philosophy is compromised by utilizing medical terminology, appropriate diagnosis codes or other tools that enable you to communicate with payers on their level, then perhaps you should be an all-cash practice. However, for those doctors who choose to accept third-party pay (including private insurance, Medicare, workers' compensation and personal-injury work), then it is in your best interest to learn their language.

Admittedly, a chiropractor whose notes consist of "neck p, C2PR, C7PL" for 30 visits probably doesn't stand much of a chance to impress an auditor with their communication skills. Essentially, they have also failed to even attempt to speak the language, failed to adequately document care, and provided notes that are impossible to read and understand to anyone but a chiropractor. Viewed from an outsider's perspective, multiple notes like this from multiple providers could certainly reinforce the viewpoint that we are second-class, substandard, "fringe" providers in the health care arena.

So, other than avoiding the minimalist approach of the previous example, how can we best prepare for the oncoming wave of audits? Here are a few "gems" that I was able to take away from my certification program to help us better get inside the minds of the auditors:

Auditors Work on Volume

The Medicare RAC program is a perfect example of this fact; RAC auditors are getting paid on a contingency basis (between 9 percent and 12.45 percent commission) for the amounts they recover. Salaried auditors still have "production goals" that motivate them toward high-volume auditing. Well-organized notes will make a good impression and disorganized slop will frustrate an auditor who wants to move quickly through your documentation.

How quickly? You would be amazed! Well-trained auditors can look at an exam note, for example, in less than a minute and determine if you hit all the required "bullets" to merit your coding level. Be forewarned: If your documentation is such a mess that you force these auditors to slow down, you may pay the price. The now-cranky auditor may make special efforts examining your every word and phrase, looking for the opportunity to make their time worthwhile. Yes, auditing is a business; a big business.

Legibility Is Often the First Downfall or Final Straw

Many chiropractors have the potential to start an audit off on the wrong foot with documentation that is incomprehensible. As in the above example, if an auditor cannot understand your terminology, if you fail to provide adequate keys toward interpreting your abbreviations, or if your handwriting is simply pitiful, your documentation is declared illegible and therefore substandard. Unfortunately, after wading through pages of your notes to find key bullets or elements needed to meet medical necessity, your sloppy handwriting or poorly organized notes also have potential to be the last straw that swings an auditor against you and your documentation. Sound a little too subjective and human? It is. But if your handwriting leaves that much in question, perhaps it's time to shop for an EMR system or move to dictation.

"Over-Documentation" Is Not the Answer

Some chiropractors feel that lengthy documentation is best. If they write five pages of SOAP notes for every patient or a novella extolling the principles of chiropractic philosophy and how it relates to their care, they mistakenly believe the auditor will be immediately satisfied because their output is so large compared to most other DCs. Wrong. Unfortunately, I have personally witnessed paragraphs of extremely detailed accident reconstruction that essentially said nothing of value. While you may need to provide background for legal purposes in a PI case, an auditor looking to see if your billing, coding and documentation match up is not impressed with the extra verbiage, nor will it provide you with a "safety net" if the required elements of your history are still not present.

Beware of Cloning

While EMR certainly has advantages in the legibility department and has the potential to help many chiropractors significantly improve the quality of their documentation, there are audit dangers lurking here as well. Auditors can easily spot "cloned" notes that essentially state the same findings over and over again, visit after visit. Even if your original note from which others were cloned was well-done, the fact that you repeatedly use the same note umpteen visits later will get you in trouble with medical necessity issues. Auditors are trained like bloodhounds to sniff out cloned notes and apply denials or postpayment demands accordingly.

Don't Ignore the Warnings

While many chiropractors feel they are being unjustly persecuted, keep in mind that audits are happening to every segment of health care. The techniques that I was taught in my auditing program were not at all specific to chiropractic, but the principles remain the same regardless, and we need to be prepared as a profession.

For those who believe all this audit talk is just paranoia, let me remind you that we should have additional motivation to improve our practices in these areas as well. Inadequate documentation is one of the most common reasons that a chiropractor faces disciplinary actions from their state board. A lack of solid documentation can also be hazardous to your defense should you ever have a malpractice case. Finally, appropriate documentation and coding are essential steps to meeting medical necessity so we can get paid for what we do.

Other than that, if you don't mind the idea of being disciplined, fined, imprisoned or working for free, you are certainly welcome to ignore all the warnings of this article and practice however you wish.

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