Dynamic Chiropractic

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If You Get a Request for Records, Respond!

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In our previous two articles, we discussed two of the main reasons for denial when chiropractic records are reviewed by Medicare contractors. As noted, inadequate treatment plans and missing signatures are two of the top reasons for denial ... when records are received. However, a larger problem is when *the records are not received at all*.

In past reviews, non-response has frequently been the No. 1 reason for denial. Examples from previous reviews include the following:

- Colorado – 57 percent non-response
- New Mexico – 43 percent non-response
- Oklahoma – 40 percent non-response
- Texas – 67 percent non-response

Previous CERT reviews have shown non-response rates of 73.4 percent and 80.6 percent, respectively.

Last year, National Government Services noted non-response as a "key issue" for denial; and most recently, Railroad Medicare said non-response accounted for 50 percent of its claim denials in the first quarter of this year.

The Impact of Non-Response

This is a huge issue. With our denial rates continually exceeding 70 percent, the number of chiropractic audits continues to rise. It is imperative that we learn what is required and comply with those requirements. Even more important is that we learn when we get a request, *we must respond*. Even if you feel your notes are less than stellar, you need to submit them. Why? Because not responding:

- *Draws attention to you.* If you submit your documentation, you have a chance it will be approved; if you don't send it in, you are guaranteed a denial. If your documentation is found to be inadequate, most likely you will be given "provider education" on proper documentation; however, by not sending in your documentation at all, it gives the impression you don't have any. Providers who show a pattern of failing to comply with requests for documentation may be subject to corrective actions. Rather than just "education," this could lead to payment suspension, monetary penalties, additional medical review, and/or an audit.[1]
- *Sends the wrong signal.* We are the only profession with this level of non-response and it makes it appear as if doctors of chiropractic are not willing to abide by the rules. Medicare contractors are authorized to request medical documentation and providers are obligated to comply (both with having the required documentation and submitting it when asked), if they expect to receive payment.[2] Due to the high rate of non-response and the subsequent high error rate, you are potentially subjecting not only yourself, but also the entire profession, to increased scrutiny. In addition, it makes it difficult to advance the profession into increased Medicare coverage and/or full physician parity.
- *Skews our denial rate.* By submitting all requested records, we could lower our denial rate by as much as 40 percentage points. This, of course, is not likely (at least at first), but we

could realistically lower the rate by approximately 15 percentage points.

- *Does not give us a clear picture of where weaknesses actually exist.* Perhaps most importantly, by having a good understanding of the reasons for denial, we can learn where to focus our educational efforts and also where there may be differences between the contractors and the profession in the interpretation of regulations.

The bottom line? When you receive a request for records, remember that it is in your best interest, and in the best interest of the profession, to respond. As Nike says, "Just do it!"

References

1. *The Medicare Program Integrity Manual*, Chapter 3, Section 7. This section also defines a "pattern" as two or more additional documentation requests that have gone unanswered.
2. The Social Security Act, Section 1833(e), states: "No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period." Section 1815(a) states, "no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period."

Editor's note: This is article #3 of a continuing series on Medicare documentation errors. "Our No. 1 Medicare Documentation Error" ran in the Jan. 15, 2014 issue and discussed treatment plans; "Are You Signing Your Notes?" appeared in the July 1, 2014 issue.

The current members of the Summit Subcommittee on Documentation are Dr. Frank Nicchi, Ms. Susan McClelland, Dr. Steven Kraus, Dr. Salvatore LaRusso, Dr. Peter Martin, Mr. Robert Moberg and Mr. David O'Bryon. Ms. McClelland served as principal author of this article.

OCTOBER 2014

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