Making Sense of the CMS Training Video

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PQRS Replacement?

- Are you tired of PQRS and attestation for EHR?
- The good news is that both of these programs are going to be replaced and combined into one program.
- This is the last year for PQRS and EHR attestation.
- The bad news is that, in typical government fashion, they have replaced these programs with a single program that is more complex.
- Medicare published the proposed rules for the replacement program for comment in the Federal Register on May 9.
- The comment period ends June 27.
- The programs are called the Merit-based Incentive Payment System (MIPS) and the Alternative Payment Model (APM) Incentive.
- The MIPS program combines three independent programs, the Physician Quality Reporting Program (PQRS), the Value-Based Payment Modifier (VM), and the Medicare Electronic Health Records (EHR) Incentive Program to work as a single program.
- The APM is a payment model that incentivizes quality and value like an expanded Medical Home model.
- Not everyone will qualify for the APM, but they will be subject to MIPS.
- MIPS combines four elements
    - Quality – 50% of the score
    - Resource use (cost) - 10% of the score
    - Clinical practice improvement activities - 15% of the score
    - Advancing care information – 25% of the score
- These combine to form a MIPS Composite Performance Score (CPS).
- The MIPS CPS can result in +/- payment adjustments up to 4% in 2019 going up to +/- payment adjustments up to 9% by 2022.
- This program is currently in the comment period.
- When the comment period ends there may be some changes.
- I would expect the final form to be released around September to November of this year.
- I will keep you informed.

CMS Training Video

- On April 16, 2015 Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MARCA).
- Section 514 of MARCA is titled Oversight of Medicare Coverage of Manual Manipulation of the Spine to Correct Subluxation and, among other things required that CMS "develop educational and training programs to improve the ability of chiropractors to provide documentation … in a manner that

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demonstrates that such services are … reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

- On December 23, CMS uploaded a 20 minute video to their YouTube channel as a response to this requirement.
- Whether this is part of a more detailed educational plan or CMS's complete response to this law remains to be seen.
- I asked subscribers to my newsletter to watch the video and let me know if they could take the information provided in this video and go back to their offices Monday morning and start providing documentation that will satisfy Medicare?
- The overwhelming response was that they could not.
- In response to this I took the 20 minute video and expanded it to 2 hours to include the practical information that you would need to comply with Medicare's laws, rules, and regulations.
- The following is excerpted from that video.
- In this segment of the video they covered:
- Published guidelines
- Problems with chiropractors documentation
- Insufficient documentation of the covered procedure
- Problems with proving medical necessity

Medicare Published Guidelines

- There are two sets of guidelines that you need to know;
- (1) The Local Coverage Determination (LCD) from your local Medicare Administrative Contractor. You can find it at your local MAC's website.
- (2) The Medicare Policy Manuals from CMS. You can find them at; https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms.html

Avoiding Insufficient Documentation

- When documenting patient encounters for Medicare you need to be specific regarding the regions of the spine.
- The number of regions billed need to match,
- The number of regions adjusted, which need to match,
- The number of regions examined, which need to match,
- The number of regions of complaint.
- In order to document a claim for 98940 you need to;
    - Have complaints in 1 to 2 spinal regions,
    - Examine the same 1 to 2 spinal regions,
    - Show PART in the same 1 to 2 spinal regions,
    - Show the specific segments adjusted in the same 1 to 2 spinal regions.
- In order to document a claim for 98941 you need to;

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  - Have complaints in 3 to 4 spinal regions,
  - Examine the same 3 to 4 spinal regions,
  - Show PART in the same 3 to 4 spinal regions,
  - Show the specific segments adjusted in the same 3 to 4 spinal regions.
- In order to document a claim for 98942 you need to;
  - Have complaints in all 5 spinal regions,
  - Examine all 5 spinal regions,
  - Show PART all 5 spinal regions,
  - Show the specific segments adjusted all 5 spinal regions.

What Makes Good Documentation?

- How do you know if your documentation is good?
- If any other doctor can read your notes and clearly understand what you have done to the patient up to this point, why you have done it and what needs to be done next.
- The following is taken from the National Committee for Quality Assurance guidelines for documentation.
  - Your records must be legible.
  - All entries must be dated and signed by the doctor.
  - If notes are handwritten, they must be in black or blue ink.
  - Entries must be written or dictated within 24 hours of the patient encounter.
  - There must be no erasures or white-outs on the records.
  - There must be no blank spaces.
  - The patient's name must be on each page or both sides of the page as applicable.
  - Noncompliance, displeasure and negative events and reactions must be documented.
  - Do not use different color pens on the same days notes.
  - Recommendations for home care, exercises, and referrals must be documented.
  - All recommended tests must have a report in the file.
  - Only standard abbreviation should be used.
  - Important: Never add or clarify an entry after you have received a subpoena for records!!
  - All patient encounters should be recorded in the patient's file.
  - This includes telephone calls and encounters with staff members as they relate to patient care.

CMS Training Video

- There are five more segments like this one, some with considerably more information in them.
- This video is designed to take what CNS specifies that they want and give you practical, actionable steps that you can take to meet their requirements.
- You can find my video at https://chirocode.com/making-sence-cms-training-video
- This video is the first step in a two step process outlined in Section 514 of MARCA.
- The second step starts on January 1, 2017 when Medicare will begin to perform more pre- and post-payment reviews.

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- They will be targeting:
    - "(A) services furnished by a such a chiropractor whose pattern of billing is aberrant compared to peers; and
    - (B) services furnished by such a chiropractor who, in a prior period, has a services denial percentage in the 85th percentile or greater, taking into consideration the extent that service denials are overturned on appeal."
- If you fall into one of these categories, you will need to get "prior authorization medical review for services … that are furnished to an individual by a chiropractor … that are part of an episode of treatment that includes more than 12 services.
- This is a wake-up call from Medicare.
- We need to get our house in order or they will crack down hard.
- Medicare believes that the problem is you and not them.
- They believe that they have done an excellent job of informing you of what they require and what they expect from you.

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