

How To Conduct a Self Audit of Medicare Patient Records

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- Select a random sample of Medicare records
- Make a copy of the samples
- Review the ACA teleseminar, " *Proper Medicare Documentation*":
https://acatoday.myicourse.com/course_catalog (There is no cost and CE credit available)
- Download and read the chiropractic LCD from WPS' website: www.wpsmedicare.com
Choose "Active Policies" in the box under J5 MAC Part B.
- Download and review the information sheet on accurate claims for chiropractic services found at
http://www.wpsmedicare.com/j5macpartb/resources/provider_types/accuratechiroclaims.shtml
- Review CMS' signature guidelines found at
<http://www.cms.gov/MLN MattersArticles/downloads/MM6698.pdf>. If the signature requirements are not met, CMS will conduct the review without considering the documentation with the missing signature. This could lead CMS to determine that the medical necessity for the service billed has not been substantiated.
- Review the Chiropractic Q & A found at
http://www.wpsmedicare.com/j5macpartb/faq/specialty/b_type_chiro_qa.shtml
- Mark/highlight any areas that may not meet the requirements or may be "weak"
 - Review your notes (or have office staff review them) as if you are the auditor, not a chiropractor, and have never seen them before
 - Compare your notes with the WPS Medicare LCD
 - Records should be typed in PART format and LEGIBLE
 - If the reviewers cannot read or understand your notes, they will be denied automatically
 - Records that are "circled/shorthand" and/or come with a "key" may be easily denied as "not legible"
 - All notes must relate to spinal misalignment or subluxation
- Your signature should be on every page/note. Stamped signatures are not acceptable.
- The Medicare number and patient name must be on every page
- Treatment plans must be in place and have measurable goals.
 - If exacerbations occur, treatment plans and goals must be updated
- Look for coding errors, such as over-coding/under-coding. Ask yourself, "Do my notes support the CPT codes based on Medicare's guidelines?"
 - All pertinent diagnosis codes should be listed in the patients chart.
 - That may mean more than four diagnosis codes. You may list as many as necessary in the chart.
 - Do diagnosis documented support medical necessity?
- Mark/write down any issues/potential issues you find
- Review onset dates
 - Are exacerbations, recurrences, new injuries, new symptoms, or new regions documented?

- Have you performed and documented re-evaluations as necessary?
- Have you documented the patient's progress?

If necessary, change the way you document based on your self audit findings

Remember, if it wasn't documented, it wasn't done! You may understand the medical necessity of the service provided, however, it must meet Medicare's guidelines and defensible in the audit.

If you have had records requested and are using this information to prepare for your audit, review ACA's audit and appeals information on their website at

http://www.acatoday.org/content_css.cfm?CID=223 and

http://www.acatoday.org/content_css.cfm?CID=222&CFID=13401&CFTOKEN=46998616

One more helpful link:

Download and review improper payments found in the past for the profession:

<http://oig.hhs.gov/oei/reports/oei-07-07-00390.pdf>