Understanding Audits:

The chiropractor's guide to administrative compliance

Ontario Chiropractic Association

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Welcome to Understanding Audits! We developed this resource as a supplement to our ***Understanding Extended Health Care*** guide. It's intended to help you proactively manage your practice to minimize the difficulty and inconvenience of an audit. We've also included some information and tips to assist you if this happens.

The purpose of this tool is to provide background information for you as an Ontario Chiropractic Association (OCA) member. It is not a substitute for legal advice.

Audit Overview

What is an EHC Audit?

Extended Health Care (EHC) coverage is an employee benefit paid for by employers (plan sponsors) and administered by the life and health insurance industry. Insurers administer this coverage according to terms and conditions set out in plan contracts with employers.

Insurance companies specifically design contracts to allow them to request additional information from patients and their health care professionals. This is a standard condition of reimbursement for insured products and services. These requests for further information are sometimes known as audits.
An audit may be minor, such as a routine claim verification, or it may be more serious and comprehensive (e.g., involve an investigation).

> **According to the Canadian Life and Health Insurance Association (CLHIA):**
>
> **"The objective of an audit is to establish that the services were provided to the patient and that the claim is eligible according to the terms of the contract."**[1]

Most of the time audits are routine and quickly resolved. However, if an audit reveals a lack of compliance with the College of Chiropractors of Ontario's (CCO) standards of care and/or insurers' policies, this can have serious consequences. These may include financial penalties (e.g., claims repayment), administrative action by the insurer, and/or disciplinary action by the CCO. In extreme cases, an insurer may decide to permanently delist you, and possibly your entire clinic. This means that you and your patients will no longer be eligible to bill or submit claims to that insurer.

If you are facing an audit and need more information and support, contact the OCA and/or the Canadian Chiropractic Protective Association (CCPA).

1 CLHIA (2019). "Provider Audits" in *Supplementary Health Insurance Explained,* https://www.clhia.ca/web/CLHIA_LP4W_LND_Webstation.nsf/resources/Consumer+Brochures/$file/SUPPLEMENTARY+HEALTH+INSURANCE+EXPLAINED.pdf

Types of Audits

Routine Audits and Claim Verifications

Routine audits usually take the form of a claim verification request. Insurers might direct these requests for information to the patient or to you, the patient's health care professional. For example, the insurer may request proof of payment. They may also ask you to confirm other details of the service or product you provided, such as time, date, duration, or nature of the service provided (e.g., initial assessment, follow-up treatment and so forth).

Claim verifications may be random, routine checks or they may be triggered by an apparent anomaly in claims data patterns. Insurers may request additional information by phone or email. If they contact you for information by phone, we recommend that you ask the insurer to resend the request by email. This will enable you to verify that the insurer has the patient's permission to obtain the requested information and confirm the insurer's credentials.

In all cases, keep detailed and accurate records of the audit process itself. Keep a record of who requested what information and when. Also, keep track of when you responded and who you responded to. If any miscommunications, discrepancies, or conflicts arise, create and securely store detailed records of this as well.

In-depth Audits

Other audits may involve a more in-depth investigation of you and/or your clinic. An insurer may initiate these types of audits to answer questions they have about specific claims or claim patterns they observe in their data. Reasons an insurer decides to pursue an investigation include:

- Claims data that suggests you are charging patients different rates for the same services according to the details of their EHC coverage. Insurers refer to this approach as "treating the plan, not the patient" and it's considered a form of benefits abuse.
- Claims data or other information to suggest that you are using incentives to drive utilization of services. For example, claims data show a sudden or dramatic increase in claim volumes when compared with a preceding period, or an insurer receives a tip from a member of the public.[2]
- Claims data that suggest you are targeting a particular group for treatment. For example, you are treating a large percentage of patients from the same employer or members of the same family for the same issue (e.g., an orthotic is prescribed for every family member).

When an insurer decides to undertake an in-depth audit, it doesn't necessarily mean they suspect fraud or abuse. It means they need further information to understand the data or data patterns they see.

It's standard practice for insurers to establish a contractual right with plan members (patients) to ask for further information, including receipts, clinical notes, billing and payment records.

2 The Canadian Life and Health Insurance Association (CLHIA) has rolled out a multi-year benefits fraud and abuse campaign, directed at members of the public. This includes a reporting portal for members of the public. See: https://fraudisfraud.ca/what-can-you-do

> **“To process claim submissions in an effective and efficient manner the insurer/benefit administrator always requires plan members to authorize the release and exchange of information between a health care provider and the insurer/benefit administrator.”**
>
> *– Canadian Life and Health Insurance Association*[3]

If you are registered for direct billing, then you have also agreed to certain information sharing and disclosure conditions. We suggest that you read and keep a copy of the terms and conditions of all direct billing arrangements that you enter into.

Remember to always keep a detailed record of the audit process itself.

Audit Dos and Don’ts

Do:

- Follow CCO standards and guidelines and keep accurate, thorough, and up-to- date clinical notes. See, in particular, CCO Standard of Practice S-002: Record Keeping.
- Ensure your website and social media accounts are consistent with CCO Standard of Practice S-016: Advertising.
- Understand what “loss leaders” and “incentives” are and why the insurance industry views “free” giveaways of non-nominal value (e.g. free shoes with orthotics) as a form of fraud.
- Understand insurers’ policies related to billing and receipts and ensure that you are following billing and receipts leading practices.
- Review every document that leaves the office with your license number on it.

Don’t:

- Submit an invoice indicating the patient paid for a service or product when they didn’t.
- Invoice for an amount that includes a co-payment that you don’t intend to collect from the patient. Likewise, don’t issue a receipt that says the patient paid the co-payment when they didn’t.
- Invoice for a service that you didn’t directly provide without indicating that the service wasn’t provided by you. For example, if someone under your supervision provided the service, such as a chiropractic student, kinesiologist or athletic therapist.
- Invoice for a treatment or service you provided to a patient under their dependent’s or family member’s name and benefit coverage.
- Have a patient sign a claim form in advance of receiving a service, product or device.

The previous examples are all benefits fraud and could cause an insurance provider to decide to delist you and/or your clinic.

3 CLHIA (2019). “Provider Audits” in *Supplementary Health Insurance Explained,* https://www.clhia.ca/web/CLHIA_LP4W_LND_Webstation.nsf/resources/Consumer+Brochures/$file/SUPPLEMENTARY+HEALTH+INSURANCE+EXPLAINED.pdf. See also: Standard of Practice S-002: Record Keeping section 5 (3): “A member with primary responsibility for a record of personal health information shall provide, on request, copies of or access to a record of personal health information to any of the following persons, **or any person authorized by… the patient…”** https://cco.on.ca/wp-content/uploads/2018/08/S-002.pdf

Spotlight on Co-payments

You may wonder why you can't waive a co-payment for a client who is having difficulty affording care. It's important to understand that co-payments are an intentional part of the health care benefits plan design.

By adding a co-payment, the employer (plan sponsor) is asking the patient (employee) to bear a portion of the cost of their care. Employers and insurers view this as a way of controlling costs and utilization rates. When a patient submits a claim for reimbursement, they must agree to the terms and conditions set out in their benefits contract, including co-payments.

The benefits contract exists between the employer and the insurance provider. Any change to these terms and conditions must be negotiated between the patient, their employer and/or their insurer.

How to Prepare for an Audit

The best way to ensure that you are prepared for an audit is to always follow CCO standards and guidelines. You should also keep accurate, thorough and up-to-date clinical notes and financial records. Ensure your receipts follow leading practices and that you and your administrative staff keep accurate records of billing and payment information. For example, an insurer may request proof that you are collecting co-payments from your patients where required.

Other information that insurers could request include:

- Clinical notes setting out an assessment of findings, diagnosis and plan of care for a patient or group of patients
- Details pertaining to financial, geographic and administrative aspects of your business(es), including whether…
    - you have multiple businesses and if so where they are located
    - your business is a sole proprietorship, partnership or corporation
    - you have financially benefited from relationships with other businesses in a specified time period
- Photographs of products or devices that you have sold or dispensed
- Lab records, including date and proof of payment for any devices you have sold or dispensed
- Prescriptions, referrals, or other records of clinical communication to and from other health care professionals
- Documentation of your certification(s) where this is required to perform a certain treatment modality (e.g., acupuncture) or to prescribe or dispense a product or device

Sometimes patients may request things from their health care provider that are not permitted, either by the CCO and/or by their insurance provider. To support you in navigating these situations we developed ***The Patient's Guide to Extended Health Care***. This guide includes FAQs that addresses some common issues in this area.

Navigating the Audit Process

When an insurance company decides to undertake an audit or in-depth investigation, they will often write to you or your clinic to request information or schedule a site visit. In some cases, insurance company employees may show up unannounced and ask to review documents. In such instances, it's reasonable for you to ask that they book an appointment to return another day. This will enable you to ensure you and your staff have adequate time to facilitate their request(s).

When an insurer writes to inform of an in-depth investigation, they will provide a timeline in which they expect to receive the requested information. It's in your best interest to comply with audits or in-depth investigations in a timely and transparent fashion.

According to the CLHIA, failure to respond to a request to provide information for audit purposes may result in:

- Delays in the reimbursement of the claims being audited
- Delays in the processing and payment of future claims
- Requests for additional, detailed documentation to support future claims
- Refusal to reimburse expenses claimed[4]

There may be instances where you require more time to respond, for example, if you are out of town on vacation or for work-related travel. If this is the case, contact the insurer as soon as possible to explain your situation and make alternate arrangements.

4 CLHIA (2019). "Provider Audits" in *Supplementary Health Insurance Explained,* https://www.clhia.ca/web/CLHIA_LP4W_LND_Webstation.nsf/resources/Consumer+Brochures/$file/SUPPLEMENTARY+HEALTH+INSURANCE+EXPLAINED.pdf.

Audit Checklist:
Leading record keeping, billing, and internal audit practices

1. Keep Detailed, Accurate and Up-to-date Records:[5]

Always ensure that your record keeping practices, including daily appointment records, patient health records and financial records, comply to the fullest extent possible with CCO's Standard of Practice S-002: Record Keeping.[6]

- ☐ Keep a daily appointment record with the surname and initials of each patient you examine or treat or to whom you render any service.
- ☐ Keep an equipment service record that is consistent with the manufacturers' recommendations.
- ☐ Keep patient health records in compliance with the CCO Standard of Practice on Record Keeping including:
  - ☐ *Patient identifying information (e.g., name, address, and so forth)*
  - ☐ *Patient history, including patient complaint(s), relevant health history and family history where relevant*
  - ☐ *Reasonable information about every initial examination, including evidence of the patient's current condition; diagnosis or clinical impression; and plan of care for the patient*
  - ☐ *Documented evidence on the performance of the necessary clinically indicated analytical/assessment procedures that demonstrate the need for care*
  - ☐ *Reasonable information about all assessments as set out in Guideline G-013: Chiropractic Assessments*
  - ☐ *All relevant diagnostic tests and diagnostic imaging that you have made or ordered for the patient*
  - ☐ *A detailed record of care of the patient, including patient consent to care*
  - ☐ *A record of periodic and regular comparative assessments, as a component of the plan of care*
  - ☐ *Each entry in the patient health record includes the date and identifying information of the person who made the entry*
  - ☐ *Accurate, up to date financial records including date and location of service; services billed; location of service; amount and form of payment received; and account balance*
- ☐ If you are using manual record keeping methods, ensure notes are detailed, legible and easily accessible when you need them. If you use abbreviations have a glossary that explains all the abbreviations that you use in your notes.
- ☐ Keep all records of clinical communication to and from other health care professionals, such as medical doctor (MD) referrals for therapy or assistive devices.
- ☐ Maintain examination records pertaining to the assistive devices you prescribe or dispense. For example, in the case of orthotics, include the order sheet, as well as records of any gait or biomechanical analysis you performed.
- ☐ Keep a record of each patient's consent to direct bill to their insurer, where applicable.

5 Section 1 of this checklist is adapted directly from the CCO Standard of Practice: S-002, §3 "Record of Personal Health Information"; Section 2 is adapted from the CLHIA Service and Supply Provider Receipt Best Practices for Group Benefit Reimbursement

6 The list below is not exhaustive and is intended as a guide. Always refer to the relevant CCO standards and guidelines for comprehensive information.

2. Follow Billing and Receipts Leading Practices

- ☐ Have clear, consistent fee schedules that are publicly accessible. For example, have signage in your office and post accurate, current schedules on practice or clinic websites to ensure that your patients, insurance providers, as well as the public have access to this information.
- ☐ Keep detailed, accurate records of each payment, which include the method of payment and the date that you received payment for services/products.
- ☐ Ensure amounts displayed on your receipts and invoices correspond to your published fee schedule. If you have applied a discount, clearly indicate this on the invoice and receipt.
- ☐ Indicate on your bills and invoices whether the patient's balance is paid in full, unpaid or partially paid with the corresponding dollar amounts clearly displayed. It's not acceptable to waive any portion of a claim that you or your patient have submitted.
- ☐ Don't issue receipts or invoices marked "paid" until after you have received payment. Clearly display the date you received payment.
- ☐ Don't leave blank fields on bills and invoices, as this may enable tampering. Mark such fields with zeros or N/A as appropriate.
- ☐ When you deliver care virtually, clearly indicate that you have done so on your receipts and invoices.
- ☐ Always clearly mark duplicate receipts **"Duplicate Receipt – Originally Issued on (insert date)."**
- ☐ Ensure the name of your patient on the invoice corresponds to the name of your patient receiving the care.
- ☐ Once you provide the service or product, you must sign your name and CCO registration number to the receipt. This is true for fully licensed chiropractors, as well as those practising with provisional licenses.

3. Ensure Consistency Across Your Practice

- ☐ If you are a sole practitioner or an associate at a clinic run by someone else, institute a system of regular (e.g., monthly, quarterly) random audits of your own receipts and invoices. This will help you to ensure documents bearing your name and registration number are complete and accurate.
- ☐ If you are a clinic owner or director, institute a system of regular (e.g., monthly, quarterly) random audits within your clinic(s). This will assist you to ensure that all staff and associates are following billing and receipts leading practices and that associates are compliant with CCO standards and guidelines (e.g., clinical note-taking).
- ☐ Put your billing and invoicing policies and protocols in writing and have all staff and associates working from your clinic review and sign off on them. Keep this practice up-to-date when there are new staff members or associates joining your practice.
- ☐ Regularly review your recording keeping and billing policies to ensure they are consistent with current CCO standards, policies, and guidelines.

If you have any additional questions that our EHC Advisory Council can potentially address or would like to share your own or your clinic's audit experience to help other members, please contact us at OCA@chiropractic.on.ca.

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