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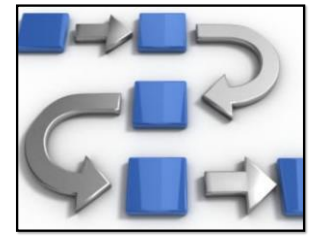
## Today's Plan



- Follow a patient from initial visit through to discharge and maintenance care
- Evaluate the total patient
- See how it's managed
- See how it's documented
- See how it's coded

2

## Our Additional Plan for Today

| | |
|---|---|
| Recognize and document | Better recognize and document the difference between active and maintenance care |
| Understand | Understand how to use a decision-making matrix to determine the reportability of active treatment and to be able to help the patient understand the distinction |
| Apply | Apply the Medicare standard of recordkeeping to intake requirements to establish a baseline for episodes of care |
| Determine | Determine whether routine visits qualify as active treatment when presented with new and updated complaints |

3

## Good Documentation Tells the Story!

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## Know Your Audience


- Another healthcare provider
- Your board
- A malpractice attorney
- Third-party payer's medical necessity auditor
- Each has different but necessary requirements for your documentation

Documentation

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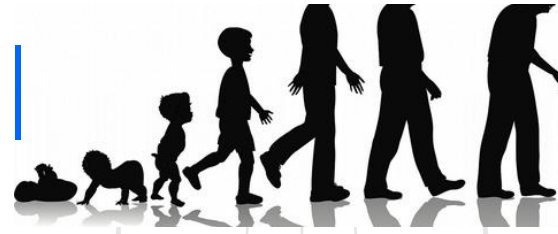

## The Life Cycle of the Patient Chart

- History
- Treatments performed
- Rationale for therapy
- Release dates from MN care
- Maintenance treatments
- Returns to MN care
- Everything that relates to how their health is managed by your office

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## What 3rd Party Payers Want to See

- Prove Medical Necessity
- Cause and start date
- End date of care
- Diagnosis match patient complaints, does that match billing and coding
- Is patient on/following a treatment plan?

7


8

## Your Patient's Flow Under Care


9

## This Now Becomes the Story You May Have to Tell


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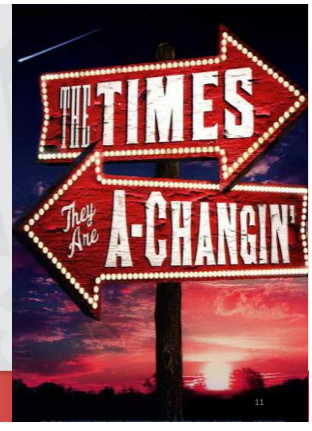
Let's be clear:

- None of this is new
- Compliance is been around for decades
- The difference now, is auditors, insurance companies and the government are bothering to look!
- Now for some "Risk Management"

Medicare

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Your Passion is Also a Regulated Business

12

## Parts of an Effective Office Compliance Program

- CMS/Medicare
- OIG compliance
- HIPAA
- OSHA
- CLIA
- Anti-Kickback Laws
- Stark Laws
- State laws
- Employment Laws

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## Who is the OIG?

Office of Inspector General's (OIG) mission is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries.

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## Government's Healthcare Oversight

HHS OIG is the largest inspector general's office in the Federal Government, with approximately 1,600 dedicated to combating fraud, waste and abuse and to improving the efficiency of HHS programs

A majority of OIG's resources goes toward the oversight of Medicare and Medicaid — programs that represent a significant part of the Federal budget and that affect this country's most vulnerable citizens

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## Federal Register Vol. 81, No. 29 February 12, 2016

(pg. 7661) We believe that undertaking no or minimal compliance activities to monitor the accuracy and appropriateness of a provider or supplier's Medicare claims would expose a provider or supplier to liability under the identified standard articulated in this rule based on the failure to exercise reasonable diligence if the provider or supplier received an overpayment.

We also recognize that compliance programs are not uniform in size and scope and that compliance activities in a smaller setting, such as a solo practitioner's office, may look very different than those in larger setting, such as a multi-specialty group.

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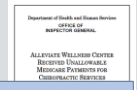
## Outliers Audited & Made Example

2013 2014 2015 2015



"Establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, correctly coded and adequately documented."

Medicare

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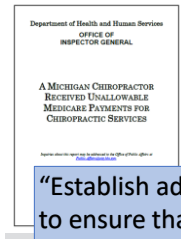
## AUGUST 2016



Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

A Michigan Chiropractor Received Unallowable Medicare Payments for Chiropractic Services

"Establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, correctly coded and adequately documented."

Medicare

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What An OIG Compliance Program IS

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Compliance Program Purpose

Integrate policies and procedures into the physician's practice that are necessary to promote adherence to federal and state laws and statutes and regulations applicable to the delivery of healthcare services


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OIG Recommends Policies and Procedures to Address THESE Risks

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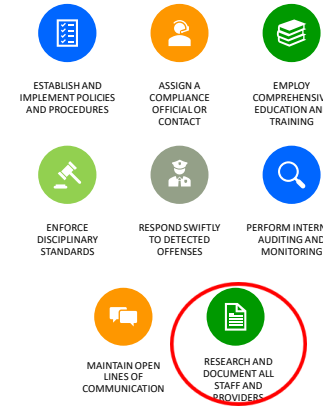
Elements of an OIG Compliance Program

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March 2015

**DOJ and HHS Announce over $27.8 Billion in Returns from Joint Efforts to Combat Health Care Fraud**

*Administration recovers $7.70 for every dollar spent to fight health care-related fraud and abuse; third-highest on record*

More than $27.8 billion has been returned to the Medicare Trust Fund over the life of the Health Care Fraud and Abuse Control (HCFAC) Program, Attorney General Eric Holder and HHS Secretary Sylvia M. Burwell announced on March 19. The government's health care fraud prevention and enforcement efforts recovered $3.3 billion in taxpayer dollars in FY 2014 from individuals and companies that attempted to defraud federal health programs, including programs serving seniors, persons with disabilities, or those with low incomes. For every dollar spent on health care-related fraud and abuse investigations in the last three years, the administration recovered $7.70. This is about $2 higher than the average return on investment in the HCFAC program since it was created in 1997. It is also the third-highest return on investment in the life of the program.

The recoveries reflect a two-pronged strategy to combat fraud and abuse. Under new authorities granted by the Affordable Care Act, the administration continues to implement programs that move away from "pay and chase" efforts targeting fraudsters to preventing health care fraud and abuse in the first place. In addition, the Health Care Fraud Prevention and Enforcement Action Team (HEAT), run jointly by the HHS Office of the Inspector General and Department of Justice (DOJ) is changing how the federal government fights certain types of health care fraud. These cases are being investigated through real-time data analysis in lieu of a prolonged subpoena and account analyses, resulting in significantly shorter periods of time between fraud identification, arrest, and prosecution.

CMS is adopting a number of preventive measures to combat fraud and abuse. Provider enrollment is the gateway to billing the Medicare program, and CMS has put critical safeguards in place to make sure that only legitimate providers are enrolling in the program. The Affordable Care Act required a CMS revalidation of all existing 1.5 million Medicare suppliers and providers under new screening requirements. CMS will have requested all revalidations by March 2015. As a result of this and other proactive initiatives, CMS has deactivated 470,000 enrollments and revoked nearly 28,000 enrollments to prevent certain providers from re-enrolling and billing the Medicare program.

CMS also continued the fiscal 2014 temporary moratoria on the enrollment of new home health or ambulance service providers in six fraud hot spots. This extension will allow CMS to continue its actions to suspend payments or remove providers from the program before allowing new providers into potentially over-supplied markets.

Similar to the technology used by credit card companies, CMS is using its Fraud Prevention System to apply advanced analytics to all Medicare Fee-For-Service claims on a streaming, national basis. The Fraud Prevention System identifies aberrant and suspicious billing patterns, which in turn trigger actions that can be implemented swiftly to prevent payment of fraudulent claims. In the second year, the system saved $210.7 million, almost double the amount identified during the first year of the program.

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Can We Say Mitigating Factor Boys and Girls?

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A "Program" is Not a "Manual"


26

The Gospel According to KMC…

"It's ridiculous to think that in today's climate you can run the business of healthcare without a mandatory compliance program. It's tantamount to thinking that you can adjust without going to chiropractic school."


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KMC's "Either/Or" Principle
Traditional Part B Medicare

Either enrolled with Medicare or don't see Medicare Patients
Either covered service or statutorily excluded service
Either Medicare responsible or patient responsible
Either active treatment or maintenance care
Either mandatory ABN or voluntary ABN
CMT is either AT or GA


Medicare Never S8990 with Traditional Part B Medicare

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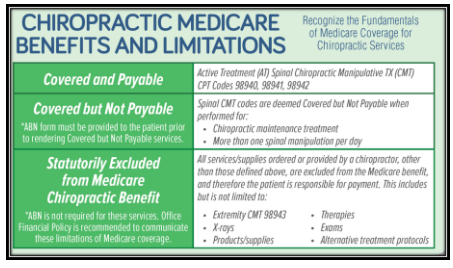
Step One: Must Know The Difference | Chiropractic is Different In Medicare

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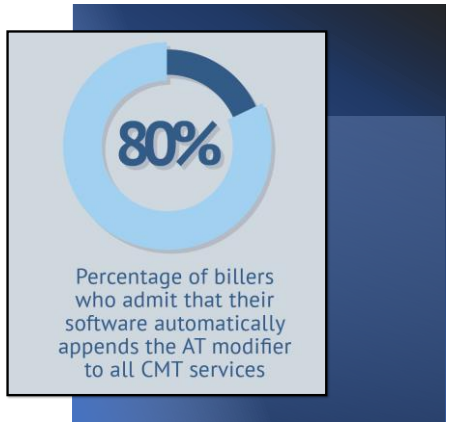


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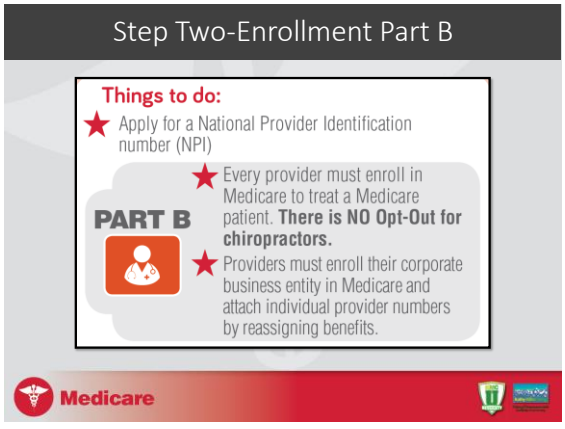


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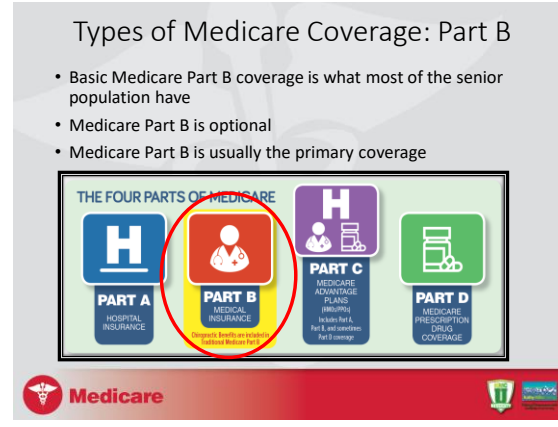


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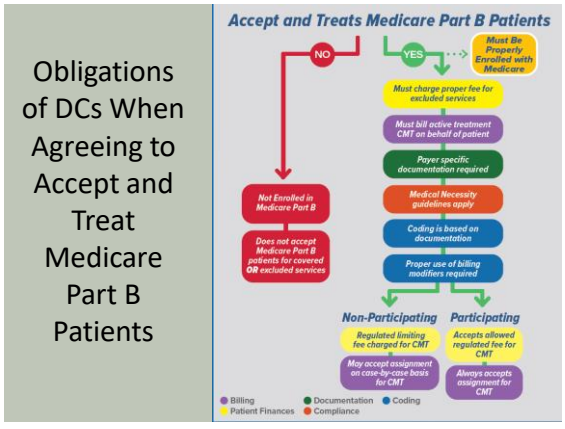


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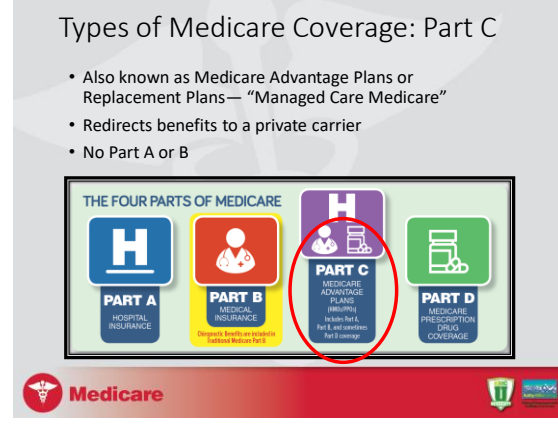


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## Step Three-Enroll in Part C Plans if Desired

PART C

Decide whether to enroll with Medicare Part C plans. Some Part C plans include additional benefits which may cover more than CMT. **NOTE:** If you are out of network, do not treat Medicare Part C patients as cash patients. Plan type impacts billing requirements. PFFS plans require a provider to accept terms or refer the patient out. Other plan types, bill the limiting fee.

Medicare

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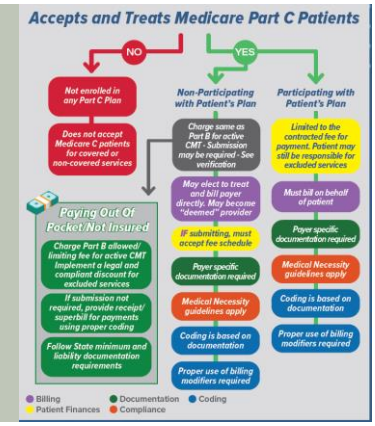
## Obligations of DCs When Agreeing to Accept and Treat Medicare Part C Patients

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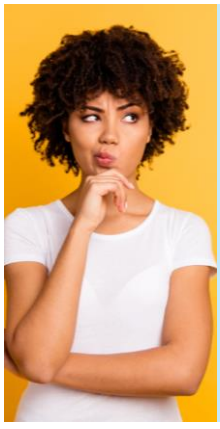

## Important Considerations Each Visit

- Is today's visit in an active episode or not?
- What visit number within the episode?
- Length of time since last visit?
- Enough to start new episode of I, B or FE?
- Full evaluation required for medical necessity?
- Always a doctor decision…not a money decision!

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## Understand and Implement Medical Necessity Definitions

The definition of Medical Necessity, per Medicare, is: The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function.

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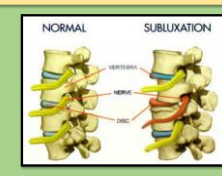
## The Opposite of Active Treatment

Maintenance therapy is defined (per Chapter 15, Section 30.5.B. of the Medicare Benefits Policy Manual) as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition.

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Fun Facts

*The patient must have a subluxation of the spine as demonstrated by x-ray or physical examination (PART)*

The date in Box 14 on the CMS-1500 Claim form indicates the first date of treatment for this episode of care, and should match the date documented in the treatment plan.

*A Medicare contractor can refuse to pay claims until additional documentation to support medical necessity is submitted.*

Medicare

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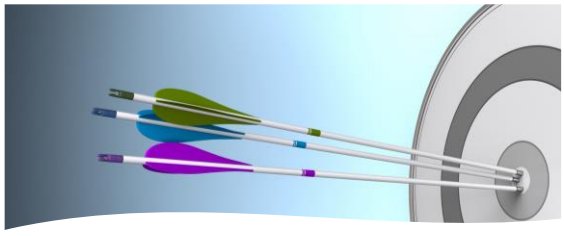

Denials Relate to Three Things

- Denied based on the benefit
- Denied based on Medical Necessity
- Denied based on coding
- Medical Review policy errors are also Medical Necessity Errors

45

Rationale for Denials Are Two-Fold

- **Binding Rationale**:
  - Medical Policy Manual
  - Medical Review Policy
  - Local Coverage Determinations (LCD)
  - Local Coverage Articles (LCA)
  - National Coverage Determinations (NCD)
- **Persuasive Rationale**:
  - Generally Accepted Standards
  - MedLearn Matters
  - Best Practices
  - Qualified and Certified Consultants
  - American Chiropractic Association
  - CPT Editorial Panel-CPT Books
  - CPT Assistant Articles

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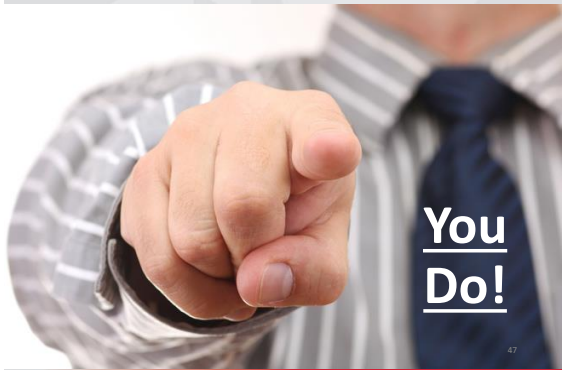
Who Determines Active vs. Maintenance?

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Documenting Medical Necessity in History or Subjective if Incident

- Include a **Mechanism of Trauma** for every new patient or new episode
- Ask leading questions of your patient to elicit a specific incident that precipitated the pain and **Functional Loss** that the patient is experiencing
- "Before experiencing your low back pain, did you slip or fall?"
- "Can you recall anything unusual that happened prior to not being able to walk?"
- Record any incident that the patient can relate that ties to the **Complaints** that brought them into your office and their **Functional Loss** from those complaints

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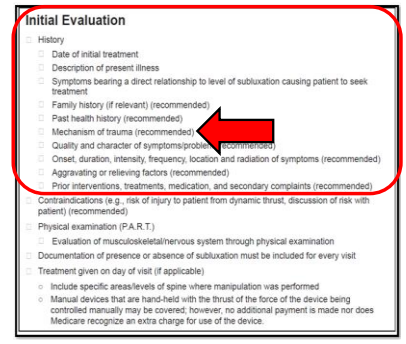
Medicare Documentation Job Aid for Chiropractic Doctors

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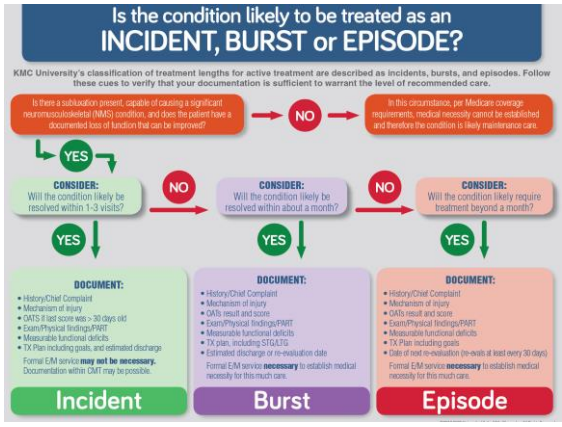


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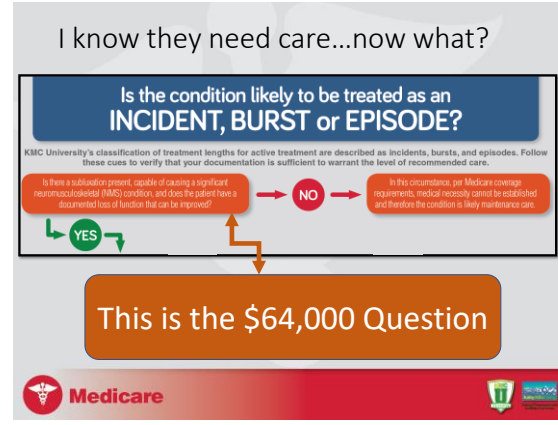


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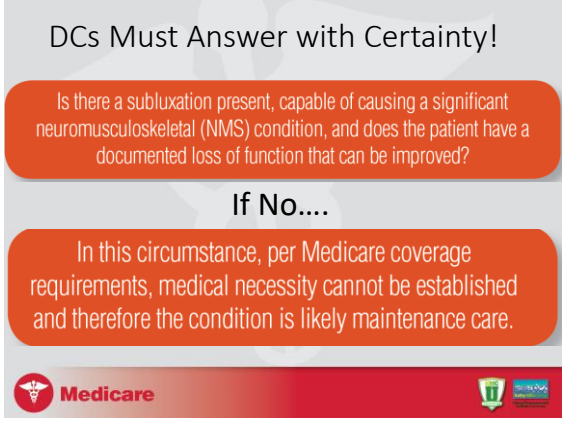


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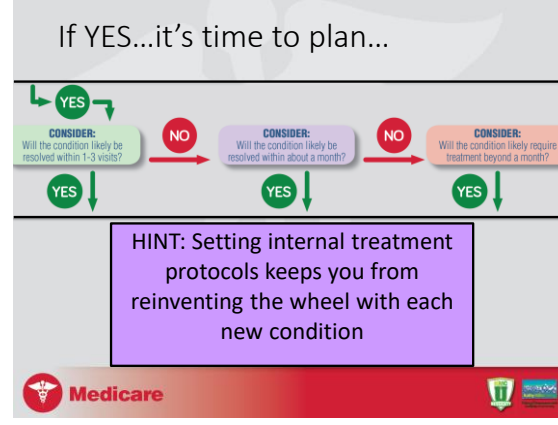


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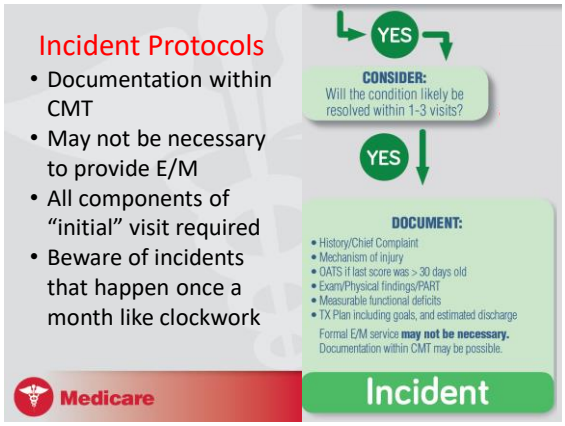


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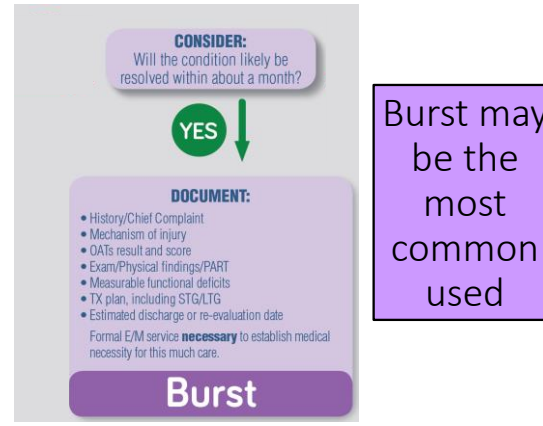


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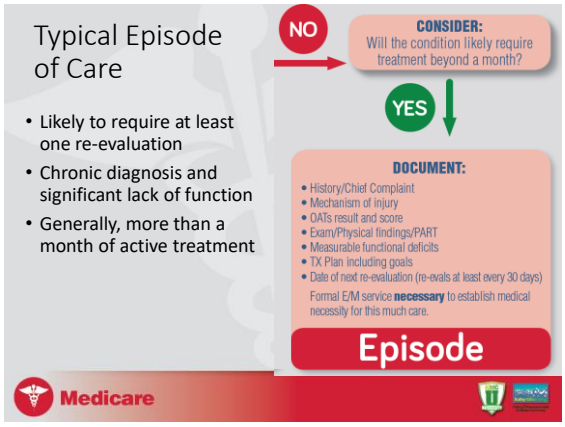


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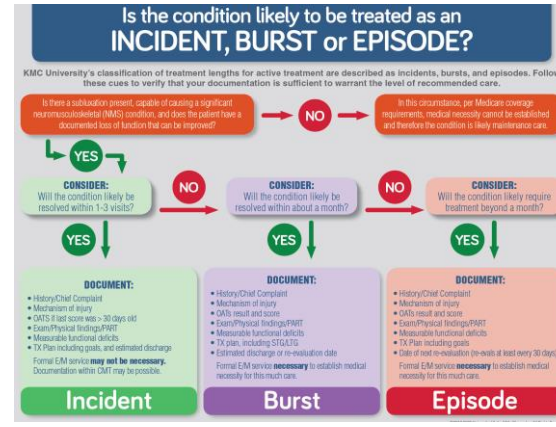


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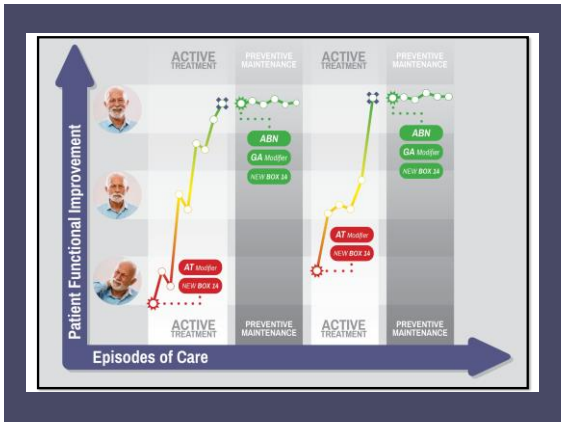


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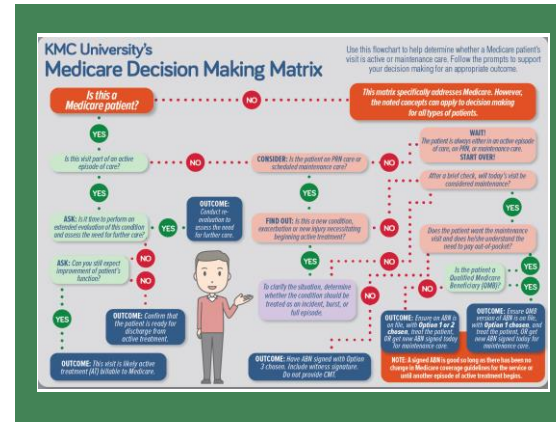


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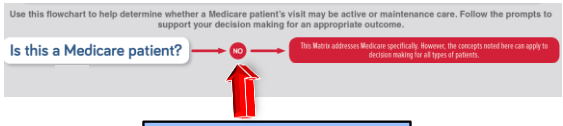
Not Medicare Only…




The concept of medical necessity, active episodes of care, and maintenance care are the same for any type of third-party pay situation

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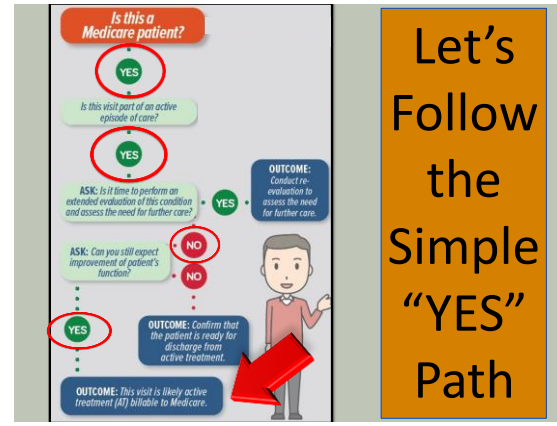


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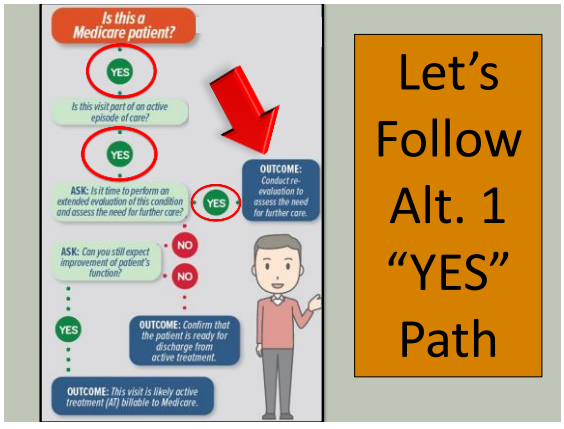


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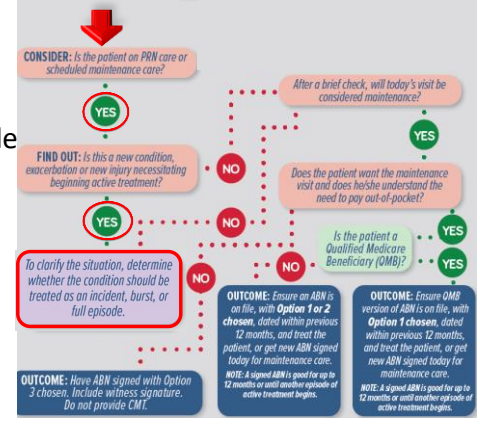
The New Episode Path

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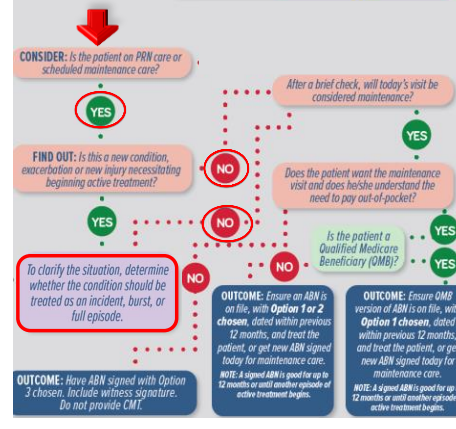


New Episode After Brief Check

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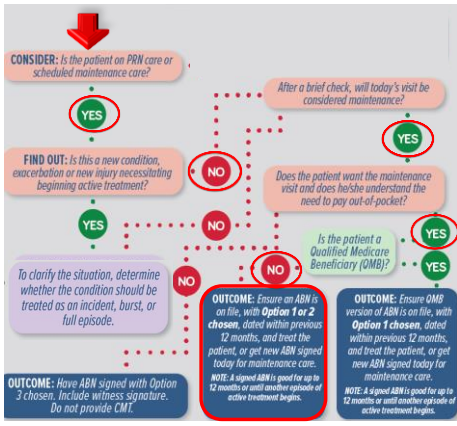


The True Non-AT Path Non-QMB

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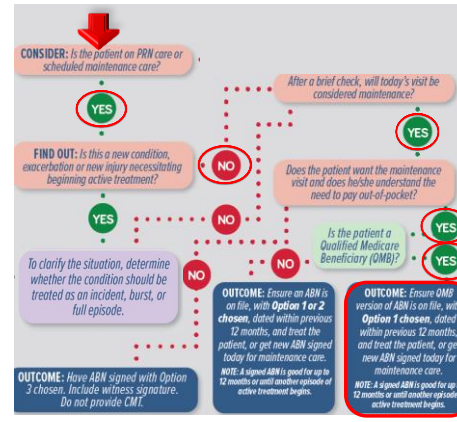


The True Non-AT Path For a QMB

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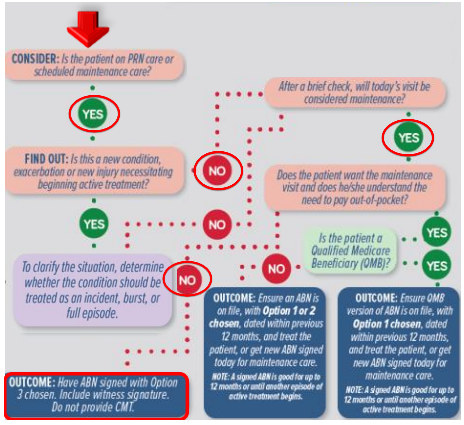


The Non-AT Path "No Thank You"

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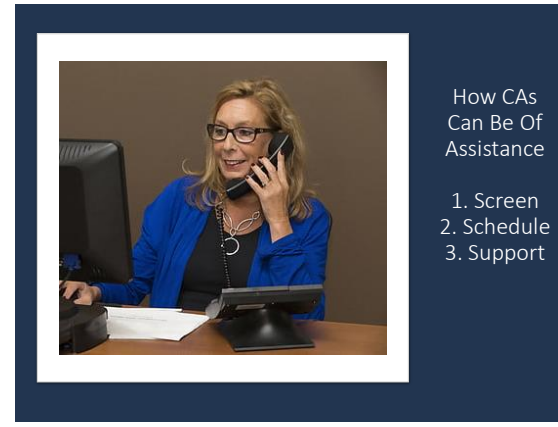


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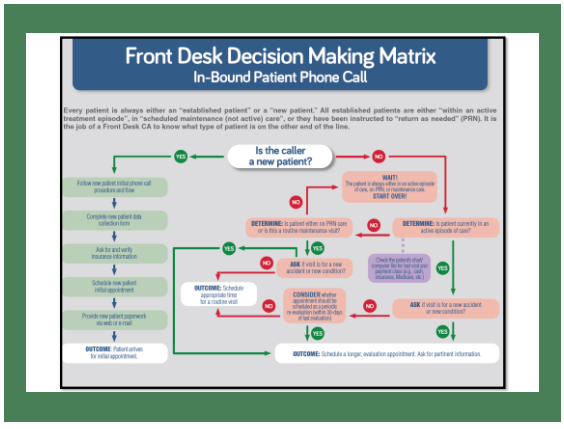


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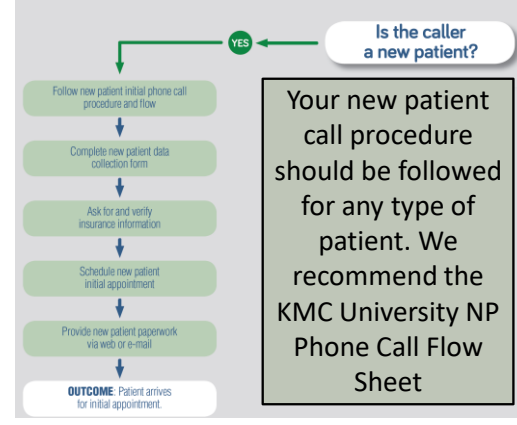


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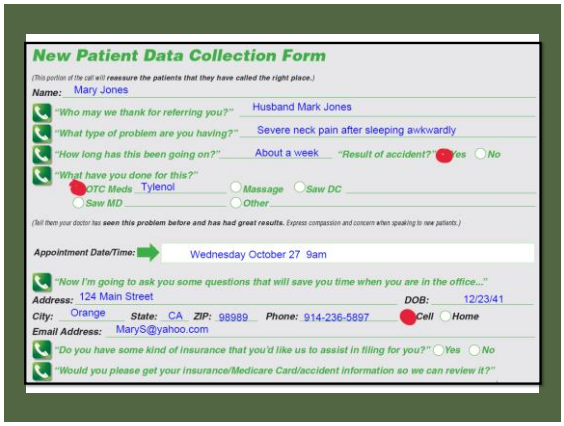


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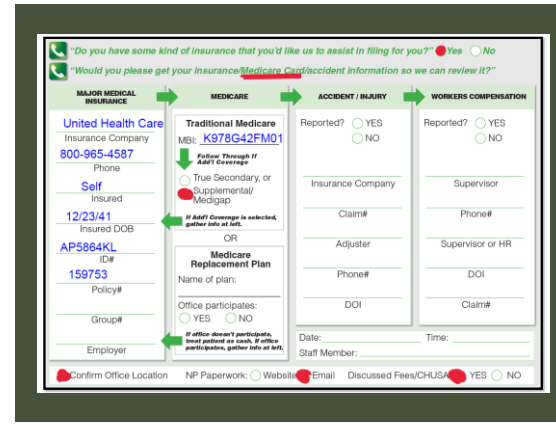


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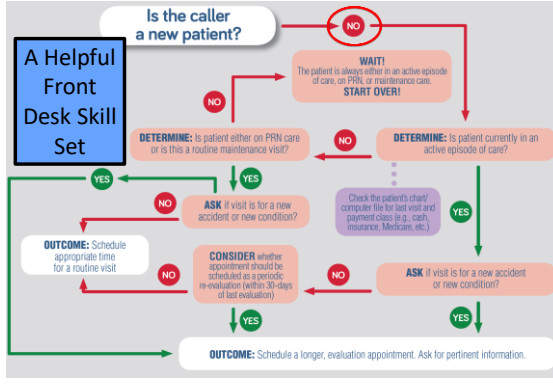


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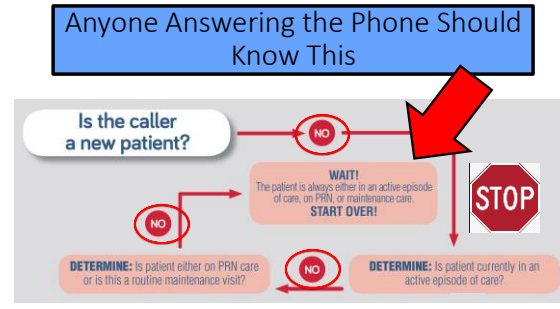


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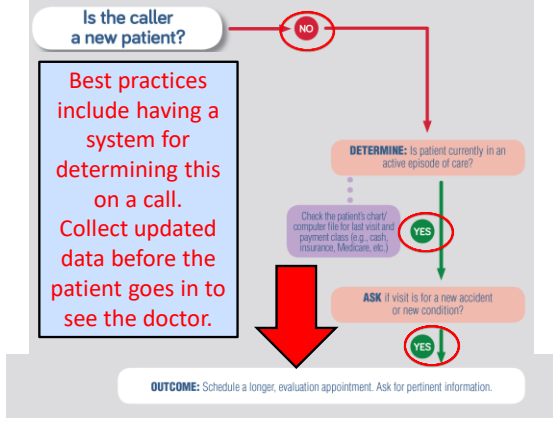


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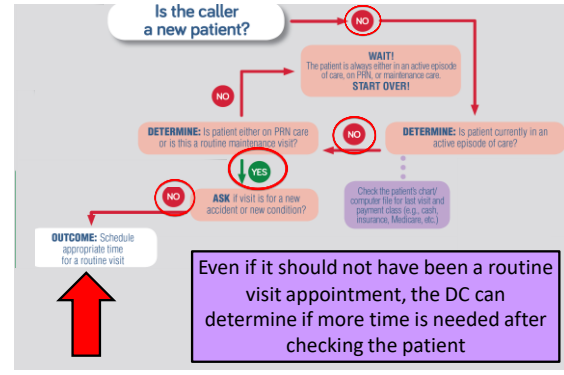


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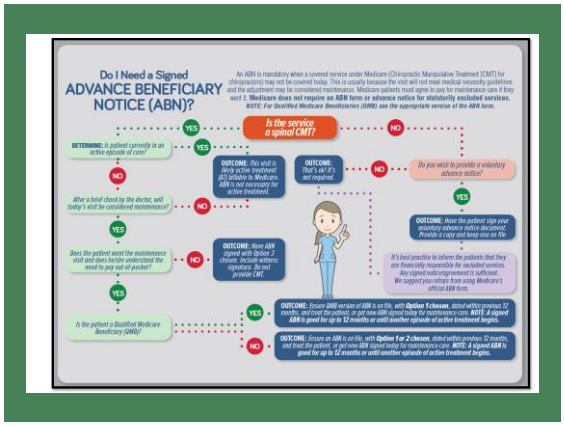


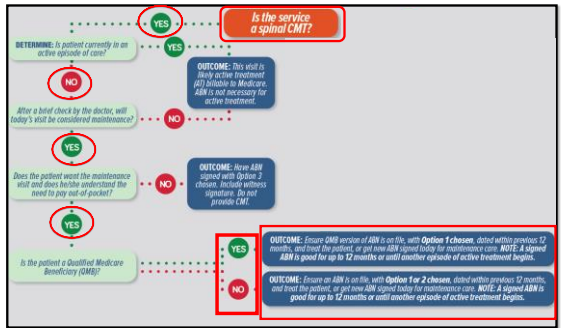

79

## Clarify Once and For All…


Hint: ABN forms are mandatory when a CMT service may not be medically necessary

80

## Let's Follow the "Yes" Track

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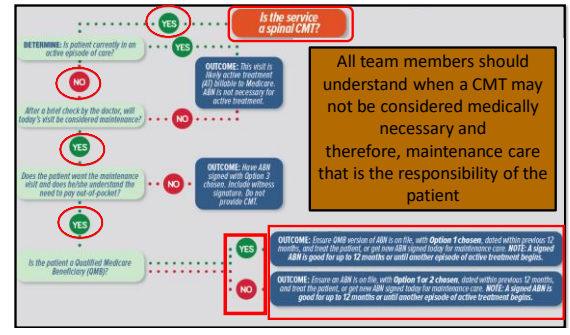
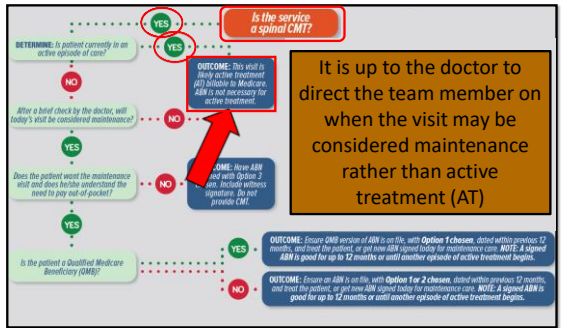
## Let's Follow the "Yes" Track




All team members should understand when a CMT may not be considered medically necessary and therefore, maintenance care that is the responsibility of the patient

82

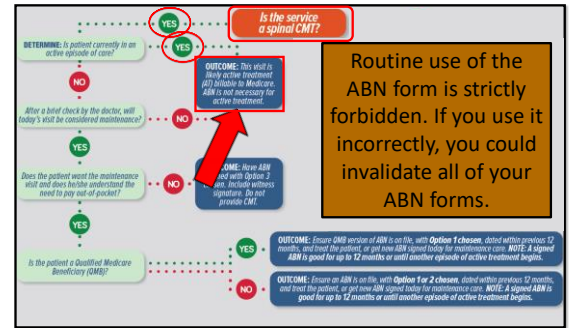
## Beware of Routine Use




It is up to the doctor to direct the team member on when the visit may be considered maintenance rather than active treatment (AT)

83

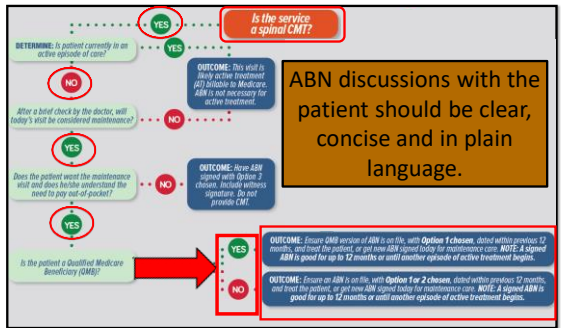
## Beware of Routine Use




Routine use of the ABN form is strictly forbidden. If you use it incorrectly, you could invalidate all of your ABN forms.

84

## Let's Follow the "Yes" Track

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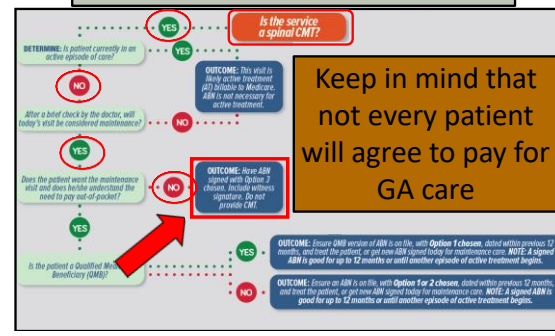
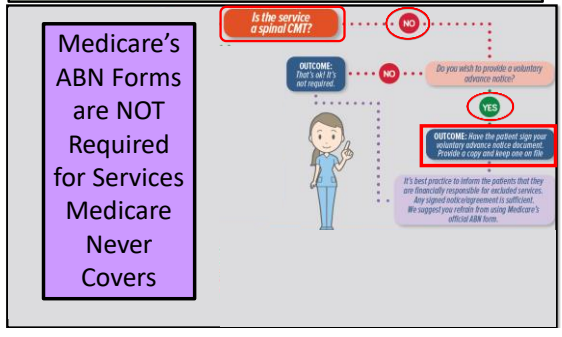
## Some Patients Won't Pay Out of Pocket




86

## Let's Follow the "Not a Spinal CMT" Track

Medicare's ABN Forms are NOT Required for Services Medicare Never Covers

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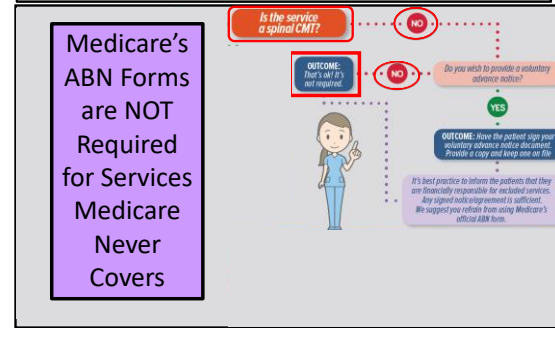
## Let's Follow the "Not a Spinal CMT" Track

Medicare's ABN Forms are NOT Required for Services Medicare Never Covers

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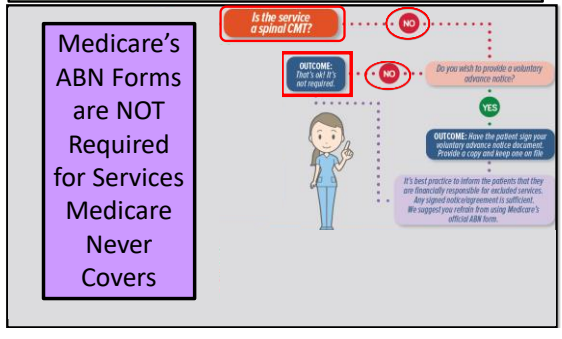
## Let's Follow the "Not a Spinal CMT" Track

Medicare's ABN Forms are NOT Required for Services Medicare Never Covers

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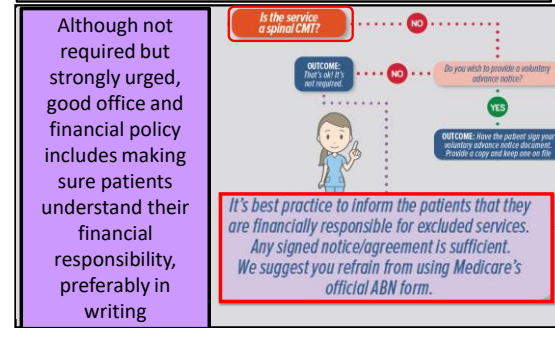
## Let's Follow the "Not a Spinal CMT" Track

Although not required but strongly urged, good office and financial policy includes making sure patients understand their financial responsibility, preferably in writing

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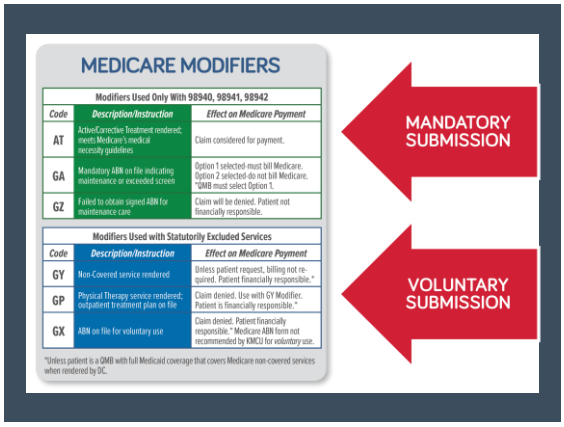


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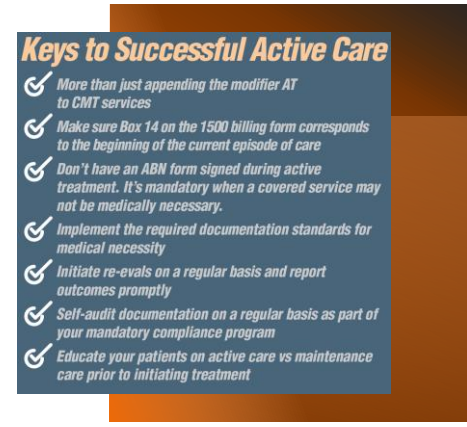


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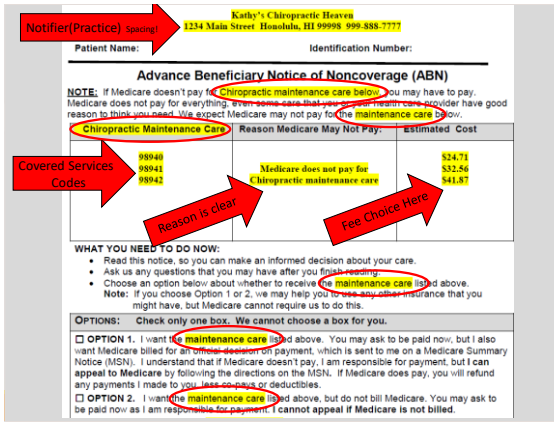


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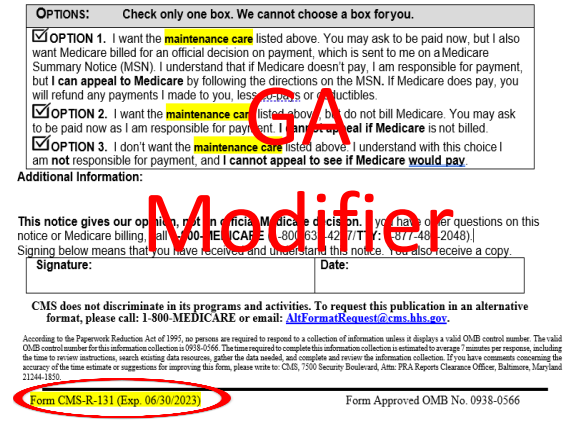


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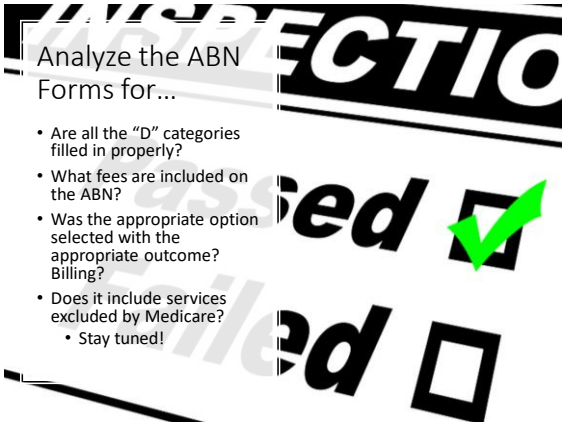


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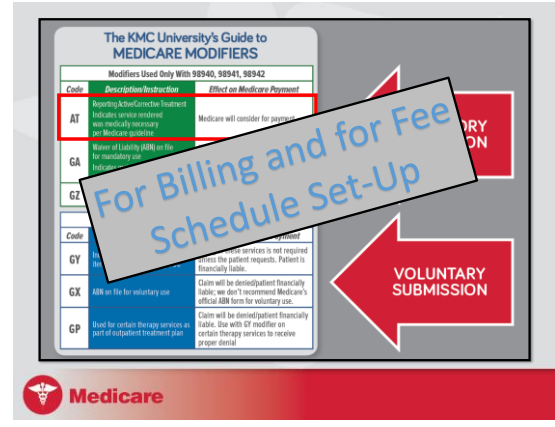


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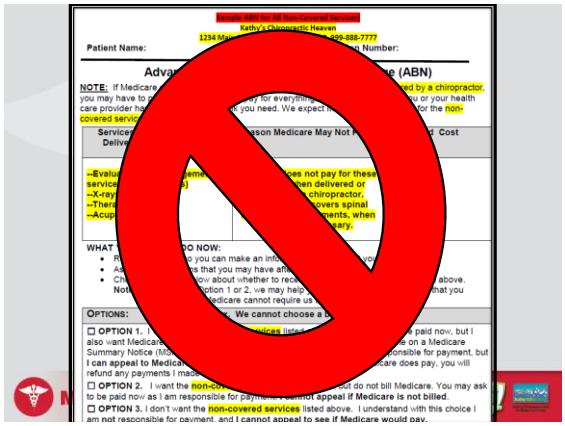


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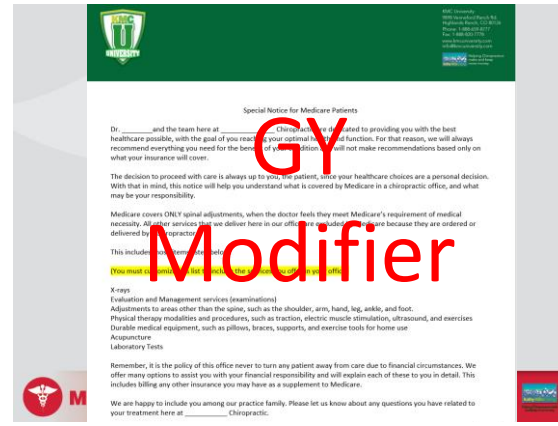


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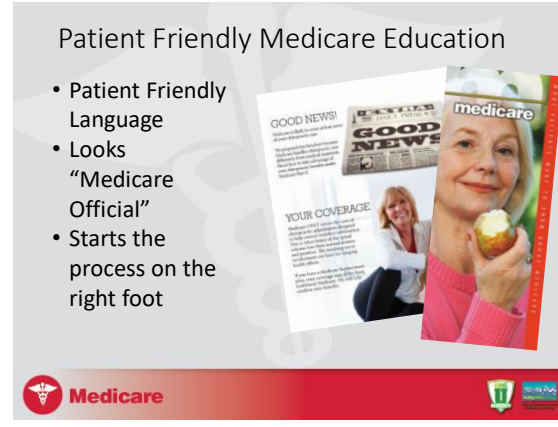


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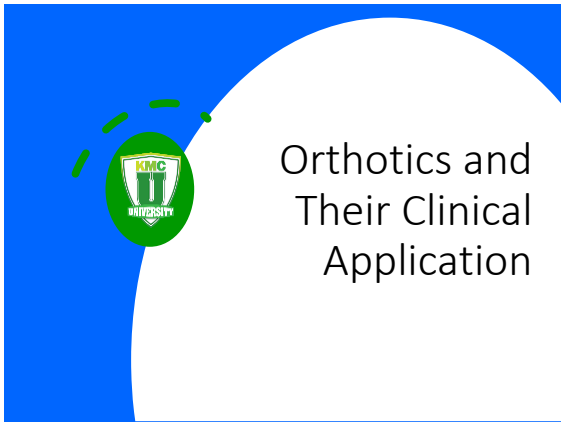
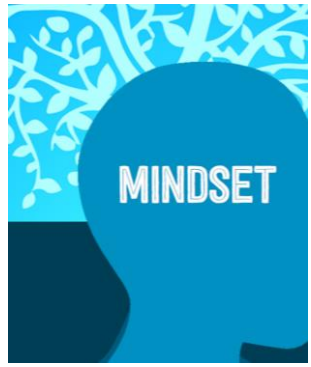



102


103

## It's a Mindset

- When the foot hits the ground, everything changes
- If this is not reality for you, get to a training event to better understand
- If this is your reality, then it becomes clear why every patient with a spinal condition should be considered for functional orthotics

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## Pathway to Orthotic Documentation

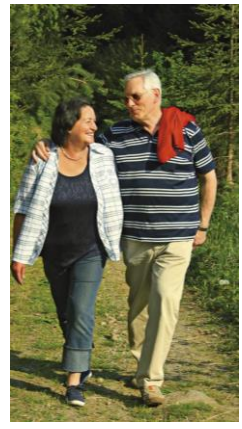
- Understand medical necessity guidelines, if any
- Patient history that supports orthotic necessity
- Description of the present illness including past treatment whether failed or effective
- Physical Exam of the affected area
- Diagnosis that meets the requirements in the MRP
- Treatment Plan that includes orthotics and ancillary treatment

106

## Patient History Supports Orthotics Prescription

- Are the symptoms affected by walking, standing, climbing, etc.?
- Does the patient avoid activity due to pain in feet or legs?
- Does the patient use any home therapies for feet or legs?

**Ask the Right Questions That May Lead to Orthotics Necessity**



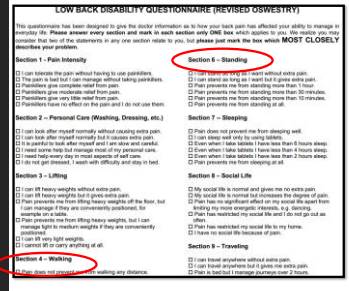
107

## Patient History Supports Orthotics Prescription

- Ask about past orthotics usage
  - "Have you ever used over the counter inserts and what was the outcome?"
- Ask about the types of treatments required in the medical review policy:
  - "Have you ever used prescription or non-prescription NSAIDS for this condition?"
  - "Have you ever had a cortisone injection and/or would you?"
  - "Have you tried stretching/exercises for the legs/feet?"

108

## Use Outcomes Assessment Tools!!



LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

**Section 1 - Pain Intensity**

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

**Section 2 – Personal Care (Washing, Dressing, etc.)**

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

**Section 3 – Lifting**

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

**Section 4 – Walking**

- ☐ Pain does not prevent me walking any distance.

**Section 6 – Standing**

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

**Section 7 – Sleeping**

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

**Section 8 – Social Life**

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

**Section 9 – Traveling**

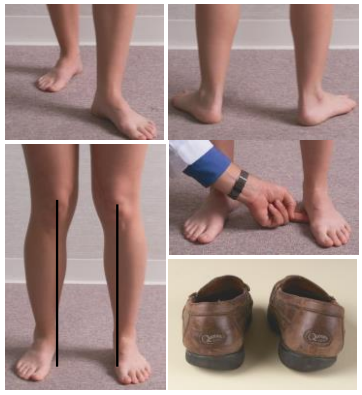
- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.

109

## Examination of the Affected Area

- Include extremity examination
- Evaluate hip, knee, ankle, foot
- Use findings to arrive at appropriate DX and treatment plan
- 5 Red Flags
- Structural x-ray anomalies, if any

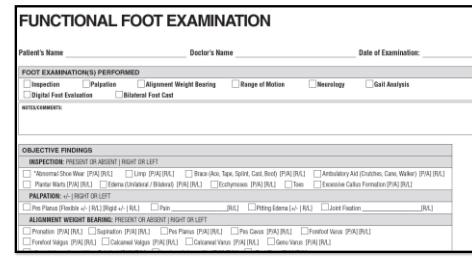
110



# 5 Red Flags

111

## Sample Foot Exam

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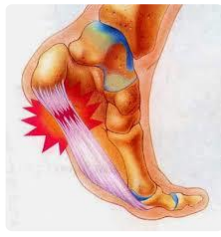

## Appropriate DX Codes

- Ensure the DX codes used are covered in the review policy if billing
- Spinal conditions may need to be sequenced secondary to extremity conditions
- The DX belongs in the initial visit documentation

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## Include Orthotics in Treatment Plan

- Include all recommendations in plan
- Link necessity with functional deficit
- Set intended goals for orthotic usage
- Include evaluation of treatment effectiveness
- Discuss impact of orthotics on overall plan

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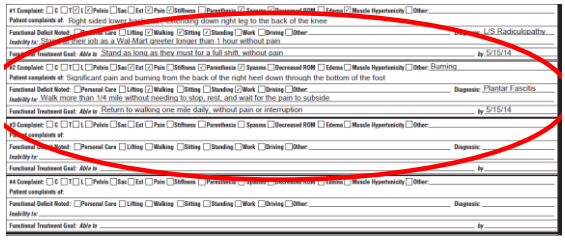


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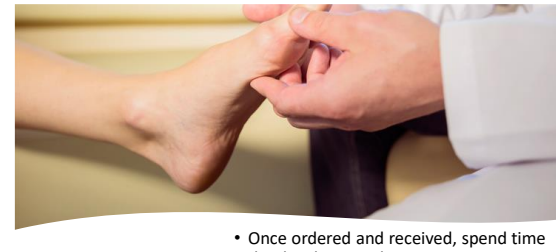

## Dispense and Train Orthotics

- Once ordered and received, spend time the day dispensed
- Discuss wearing schedule
- Insert in shoes
- Review gait
- Confirm that the fit is good
- Recheck during wearing schedule

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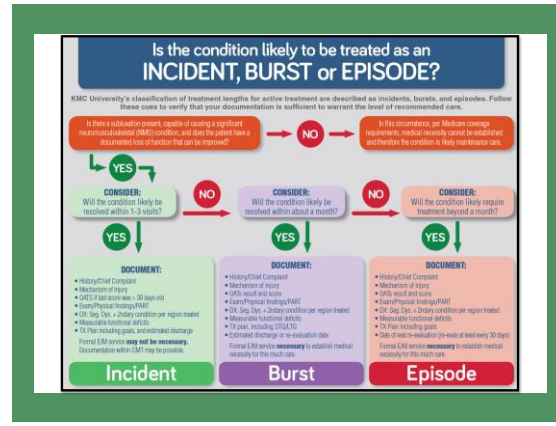
## Types and Styles of Initial Visits

- Initial NP Visits
- Established Patient- New Condition
- Established Patient- New Injury
- Established Patient- Additional Condition
- Use E/M formatting, look and feel

121

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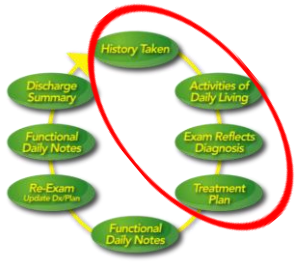
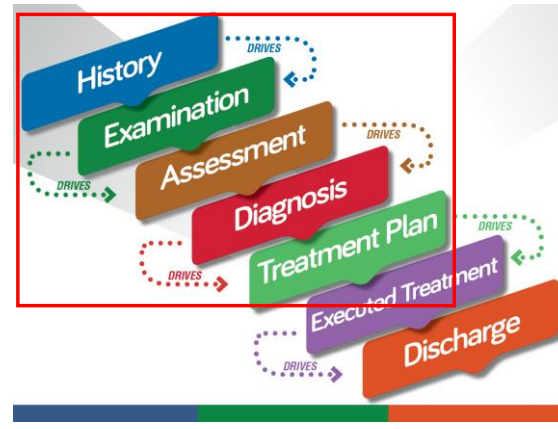



## What 3rd Party Payers Want to See

- Proof of Medical Necessity
- Cause and start date
- End date of care
- Diagnosis matches patient complaints; does that match billing and coding
- Is patient on/following a treatment plan

123

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## Medicare Documentation Guidelines in the Absence of Others

| Initial Visit | Subsequent Visits |
|---|---|
| •History | •History |
| •Description of Present Illness | •Review of chief complaint |
| •Physical Exam | •Physical Exam |
| •Diagnosis | •Documentation of daily treatment |
| •Treatment Plan | •Progress related to treatment goals/plan |
| •Date of initial treatment | |

Documentation

125

## What About an Incident?

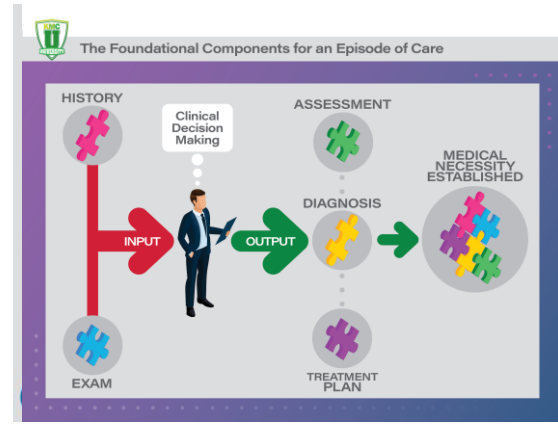
- A brief episode of care may not require full E/M
- Simple flare-ups necessitating 2-3 visits can be documented differently
- Components of initial visit are still required to establish the episode
- Examples are provided in the modular training

126

## The Not-So-Easy Stuff

- History that relates to MN treatment
- Examination
- Rationale for treatments
- Treatment plan
- Assessment -ALL of these must be written in the documentation


127

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## The Easy Stuff

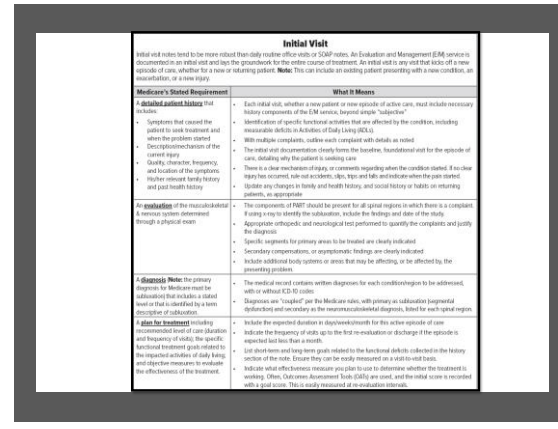
**Daily Treatment**

- What was done for the patient
- This should be supported by the treatment plan that was formulated from the history and examination findings

**Maintenance/wellness treatments**

- Document to state/federal standards


129

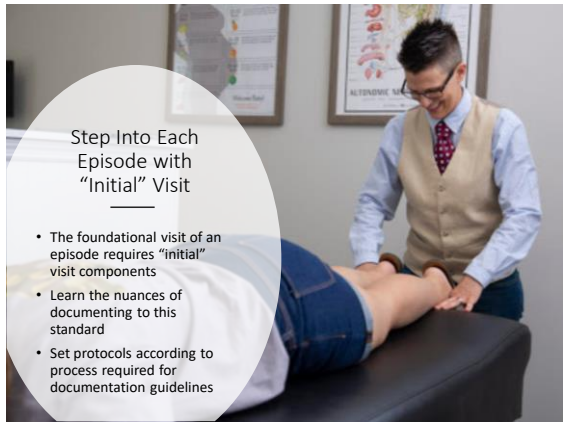


**Initial Visit**

Initial visit notes tend to be more robust than daily routine office visits or SOAP notes. An Evaluation and Management (E/M) service is documented in an initial visit and lays the groundwork for the entire course of treatment. An initial visit is any visit that kicks off a new episode of care, whether for a new or returning patient. **Note:** This can include an existing patient presenting with a new condition, an exacerbation, or a new injury.

| Medicare's Stated Requirement | What It Means |
|---|---|
| A **detailed patient history** that includes:<br>• Symptoms that caused the patient to seek treatment and when the problem started<br>• Description/mechanism of the current injury<br>• Quality, character, frequency, and location of the symptoms<br>• His/her relevant family history and past health history | • Each initial visit, whether a new patient or new episode of active care, must include necessary history components of the E/M service, beyond simple "subjective"<br>• Identification of specific functional activities that are affected by the condition, including measurable deficits in Activities of Daily Living (ADLs)<br>• With multiple complaints, outline each complaint with details as noted<br>• The initial visit documentation clearly forms the baseline, foundational visit for the episode of care, detailing why the patient is seeking care<br>• There is a clear mechanism of injury, or comments regarding when the condition started. If no clear injury has occurred, rule-out accidents, slips, trips and falls and indicate when the pain started.<br>• Update any changes in family and health history, and social history or habits on returning patients, as appropriate |
| An **evaluation** of the musculoskeletal & nervous system determined through a physical exam | • The components of PART should be present for all spinal regions in which there is a complaint. If using x-ray to identify the subluxation, include the findings and date of the study.<br>• Appropriate orthopedic and neurological test performed to quantify the complaints and justify the diagnosis<br>• Specific segments for primary areas to be treated are clearly indicated<br>• Secondary compensations, or asymptomatic findings are clearly indicated<br>• Include additional body systems or areas that may be affecting, or be affected by, the presenting problem |
| A **diagnosis** (**Note:** the primary diagnosis for Medicare must be subluxation) that includes a stated level or that is identified by a term descriptive of subluxation | • The medical record contains written diagnoses for each condition/region to be addressed, with or without ICD-10 codes<br>• Diagnoses are "coupled" per the Medicare rules, with primary as subluxation (segmental dysfunction) and secondary as the neuromusculoskeletal diagnosis, listed for each spinal region. |
| A **plan for treatment** including recommended level of care (duration and frequency of visits), the specific functional treatment goals related to the impacted activities of daily living, and objective measures to evaluate the effectiveness of the treatment. | • Include the expected duration in days/weeks/month for this active episode of care<br>• Indicate the frequency of visits up to the first re-evaluation or discharge if the episode is expected last less than a month.<br>List short-term and long-term goals related to the functional deficits collected in the history section of the note. Ensure they can be easily measured on a visit-to-visit basis.<br>• Indicate what effectiveness measure you plan to use to determine whether the treatment is working. Often, Outcomes Assessment Tools (OATs) are used, and the initial score is recorded with a goal score. This is easily measured at re-evaluation intervals. |

130



Step Into Each Episode with "Initial" Visit

- The foundational visit of an episode requires "initial" visit components
- Learn the nuances of documenting to this standard
- Set protocols according to process required for documentation guidelines

131


Documentation Standards of Medical Necessity

132

## Is All Care Medically Necessary?

| Clinically Appropriate Care | Medically Necessary Care |
|---|---|
| • Maintenance care<br>• Supportive care<br>• Palliative care<br>• Life enhancing and wellness care<br>• Symptom relieving only<br>• Care that doesn't have as its goal improved function and correction | • Acute problems<br>• Care that can provide measurable functional improvement<br>• Chronic care with expected functional improvement<br>• Often defined by the carrier's medical policy |

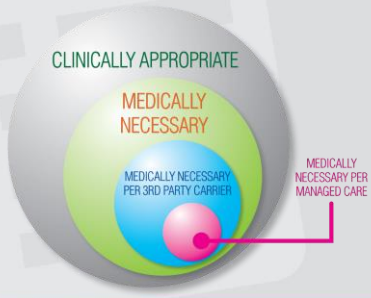
Documentation

133

Medical Necessity = Care parameters set and defined by third-party payers

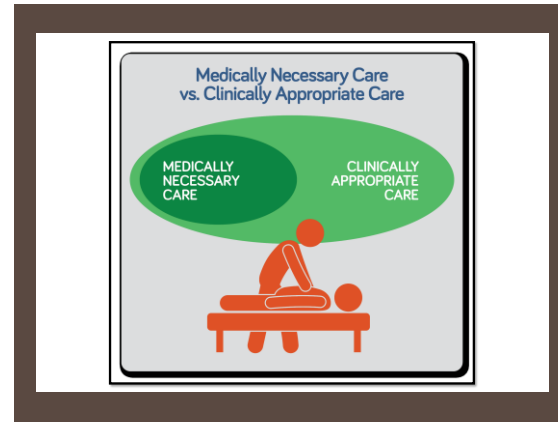
134

## HOW IS CARE DEFINED?




Documentation

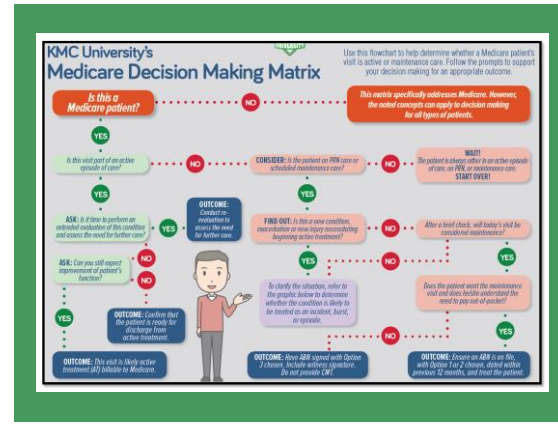
135




136


But You Have to Back it Up!

137




138

## Medicare Documentation Guidelines in the Absence of Others

| Initial Visit | Subsequent Visits |
|---|---|
| •History | •History |
| •Description of Present Illness | •Review of chief complaint |
| •Physical Exam | •Physical Exam |
| •Diagnosis | •Document daily treatment |
| •Treatment Plan | •Progress related to treatment goals/plan |
| •Date of initial treatment | |

Documentation

139

## Let's Become Auditors

141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## History Drives the Episode

- No matter the reason for the episode, the history must contain critical elements
- Whether an E/M history or an "S" history, all components must be included for medical necessity

143

## Board of Examiners' Expectations (none for AL)

The Voice of Colorado Chiropractic Since 1917

**Rule 22: Record Keeping Requirements**

Excerpted from Colorado State Board of Chiropractic Examiners Rules and Regulations

Documentation of the patient's health history, presenting complaint(s), progression of care, diagnosis, prognosis and treatment plan must be reflected in the record keeping and written reports of the patient file. Records are required to be contemporaneous, legible, utilize standard medical terminology or abbreviations, contain adequate identification of the patient, contain adequate identification of the provider of service and indicate the date the service was performed. All professional services rendered during each patient encounter should be documented. Any addition or correction to the patient file after the final form shall be signed and dated by the person making the addition or correction. The following minimum components must be documented within the patient file:

A. Initial Patient Visit:
1. History:
   a. Chief complaint(s) described in terms of onset, provocative, palliative, quality, radiation, setting, and timing.
   b. Surgical, hospitalization, past/recent illness, trauma, family, social, past/recent system review, and past/recent allergies.
   c. Non-prescription, prescription, botanical, homeopathic medicines, and vitamin supplements.
   d. A reasonable effort should be made to obtain and review pertinent records as clinically indicated from other health care providers, imaging facilities, or laboratories.

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## SO MUCH MORE

## Medicare's Initial OV History Guidelines

(CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2.2)

- Documentation Requirements for History: The history recorded in the patient record should include the following:
- Symptoms causing patient to seek treatment
- Family history if relevant
- Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history)
- Mechanism of trauma
- Quality and character of symptoms/problem
- Onset, duration, intensity, frequency, location, and radiation of symptoms
- Aggravating or relieving factors; and prior interventions, treatments, medications, secondary complaints

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## Medicare's Initial OV History Guidelines

- Description of the present illness including:
  - Mechanism of trauma
  - Quality and character of symptoms/problem; Onset, duration, intensity, frequency, location, and radiation of symptoms; Aggravating or relieving factors; Prior interventions, treatments, medications, secondary complaints; and Symptoms causing patient to seek treatment.
  - These symptoms must bear a direct relationship to the level of subluxation.
  - The symptoms should refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro) and be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, etc.
- Vertebral pinching of spinal nerves may cause headaches, arm, shoulder, and hand problems as well as leg and foot pains and numbness.
- Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such.
- The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited.
- A statement on a claim that there is "pain" is insufficient. The location of pain must be described and whether the vertebra listed can produce pain in the area determined.

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## Medicare Documentation Guidelines in the Absence of Others

| Initial Visit | Subsequent Visits |
|---|---|
| •History | •History (S of SOAP) |
| •Description of Present Illness | •Review of chief complaint |
| •Physical Exam | •Physical Exam |
| •Diagnosis | •Document daily treatment |
| •Treatment Plan | •Progress related to treatment goals/plan |
| •Date of initial treatment | |

Documentation

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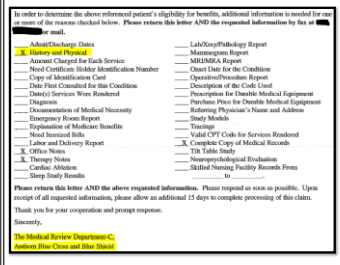
## Medical Review Expects History



In order to determine the above referenced patient's eligibility for benefits, additional information is needed for one or more of the reasons checked below. **Please return this letter AND the requested information by fax at [redacted] or mail.**

| | |
|---|---|
| ___ Admit/Discharge Dates | ___ Lab/Xray/Pathology Report |
| _X_ History and Physical | ___ Mammogram Report |
| ___ Amount Charged for Each Service | ___ MRI/MRA Report |
| ___ Need Certificate Holder Identification Number | ___ Onset Date for the Condition |
| ___ Copy of Identification Card | ___ Operative/Procedure Report |
| ___ Date First Consulted for this Condition | ___ Description of the Code Used |
| ___ Date(s) Services Were Rendered | ___ Prescription for Durable Medical Equipment |
| ___ Diagnosis | ___ Purchase Price for Durable Medical Equipment |
| ___ Documentation of Medical Necessity | ___ Referring Physician's Name and Address |
| ___ Emergency Room Report | ___ Study Models |
| ___ Explanation of Medicare Benefits | ___ Tracings |
| ___ Need Itemized Bills | ___ Valid CPT Code for Services Rendered |
| ___ Labor and Delivery Report | _X_ Complete Copy of Medical Records |
| _X_ Office Notes | ___ Tilt Table Study |
| _X_ Therapy Notes | ___ Neuropsychological Evaluation |
| ___ Cardiac Ablation | ___ Skilled Nursing Facility Records From |
| ___ Sleep Study Results | ___ _____ to _____ |

**Please return this letter AND the above requested information.** Please respond as soon as possible. Upon receipt of all requested information, please allow an additional 15 days to complete processing of this claim.

Thank you for your cooperation and prompt response.

Sincerely,

The Medical Review Department C,
Anthem Blue Cross and Blue Shield

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## Job 1: Doctor Listening

- Patient history, written and spoken
- Ask thoughtful questions
- Chief and additional complaints
- HPI, ROS, and PFSH
- Begin to formulate thoughts about examination

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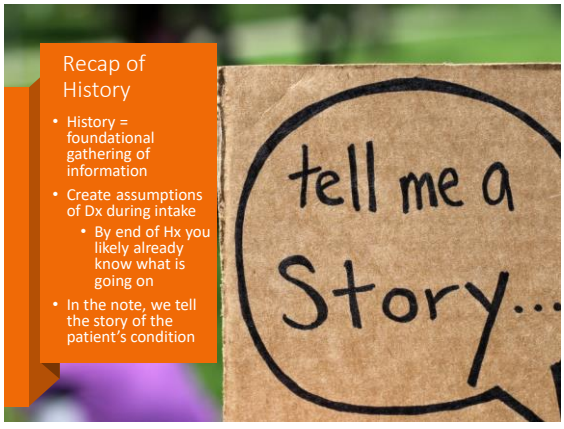


## Recap of History

- History = foundational gathering of information
- Create assumptions of Dx during intake
  - By end of Hx you likely already know what is going on
- In the note, we tell the story of the patient's condition

150

## OATs Defined

An outcome measure is a tool used to assess a patient's current status

Outcome measures may provide a score or an interpretation of results

Used to describe the extent to which chiropractors utilize standardized outcome and various clinical measures to systematically document patients' baseline health status and responses to treatment

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## Two Very Important Reasons to Use OATs

- Excellent tool to use as "Evaluation of Treatment Effectiveness"
- Use OATs to assist with identifying functional limitations for treatment goals


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## Don't Only Track Pain

- Patients consider pain differently
- Because it can vary so much from visit to visit, it's not reliable as an only source
- Even if patients learn to "game" the OATs system, it's still more quantified than pain only


Documentation

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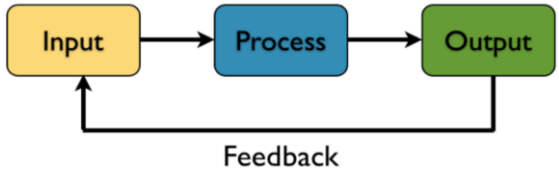
## History = Both Input and Output

- Inputs:
  - Patients written history or update
  - OATs
  - Additional concerns in ROS and PFSH
  - Pain questionnaires
- Outputs:
  - Doctor's consultation notes
  - Expansion of written information
  - Dig deeper beyond what the patient wrote and reported
  - Expand upon OATs to identify functional deficits




154

## Exam Should Be Driven by History

Documentation

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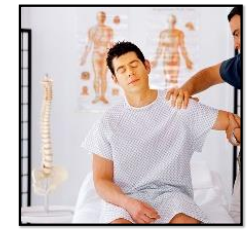
## Job 2: Doctor Finding

- Driven by history
- Include tests and measurements to quantify history
- Record everything in the patient's record
- Determine whether additional diagnostic testing rationale exists



160

## How HX Relates to Examination

- Examination is needed to substantiate history findings
- Each piece of Hx has meaning
- Exam objectively supports subjective data from patient

161

## How HX Relates to Examination

- Use exam to prove your Dx from history
  - Positive Hx components become ortho/neuro/palpation examinations
- Physical exam confirms or disproves your assumptions about your Diagnosis

162

## How HX Relates to Examination

- Observation
- Inspection
- Selective tissue tension
- Resisted isometric
- Neuromuscular
- Functional assessment
- Special tests

Quantifies condition with objective data
We choose the test to confirm our assumptions from the history

163


Recap of History

- History is where we gather information about what is wrong with the patient-each compliant
- Create assumptions of DX during intake
  - By end of Hx you likely already know what is going on
- In the note, we tell the story of the patient's condition

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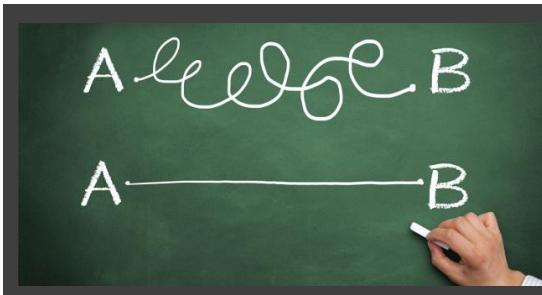


**Making Sense of Tests**

- + HX finding = Objective test
- Radiating complaint = corresponding ortho/neuro test
- Palpation of areas of complaint
- Direct line between Hx and exam

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## Making Sense of Tests

| Information from History | Action in Examination |
|---|---|
| • CC – Neck Pain | • CC – Examine neck |
| • HPI | • HPI |
| – Dull and achy | – Dull and achy = Muscle evaluation of cervical region, ortho testing |
| – Sometimes get headaches when working at computer | – Headaches = cranial nerves, ortho/neuro for disc involvement |
| – Movement of neck sometimes increases pain | – Movement = Eval ROM |
| • Social Hx | • Social Hx |
| – Occupation office assistant | – Postural evaluation during work duties |

Documentation

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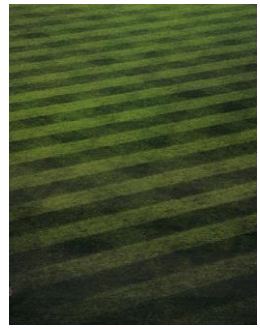
## Looking into Left Field

- Pain in neck = physical exam of neck
  - Not inherently MN to examine feet
  - Clinically Appropriate to exam feet



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## Examining Areas other than CC

In 3rd Party Payer Land

- They don't understand connection of the whole body
- They think you are looking in the wrong direction
- The picture needs to be explained

One Symptom → Cause of Problem

Documentation

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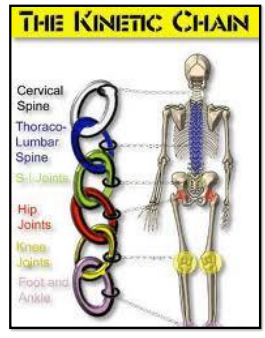
## Connecting the Exam in MN

- Must explain connection of exam regions if not directly related
- Not everyone realizes that spine and spinal anatomy is connected… we must explain

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## Example

Why are you examining the feet for low back CC?


Assessment:

The patient's chronic low back pain that increases in severity when standing on a concrete floor while at work provided rationale to examine bilateral feet for loss of arch. The loss of arch in the feet would likely cause increased postural distortions resulting in low back pain.

*Treatment of the feet

Dx must be foot not Low Back for MN

Documentation

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## Example

Assessment:

Despite the chief complaint of sciatica like symptoms, examination of the cervical region was warranted. Abnormal tissue tone was present during general palpation of the cervical spine. The asymmetry of the cervical spine at C4-6 combined with spastic muscular of the same region have a direct correlation to the provocation of radiculopathy that occurs when the patient rotates her neck beyond 15 degrees. A + Soto Hall indicates that the tension on the spinal cord is likely resulting from a subluxation in the cervical region.

Documentation

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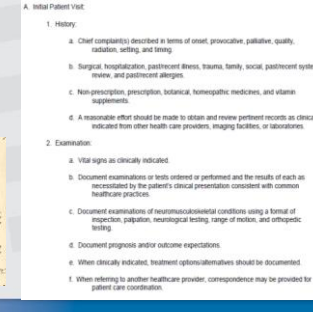
## If No Direct 3rd Party MN Rules Apply

- Follow State scope of practice rules for documenting exam

Documentation

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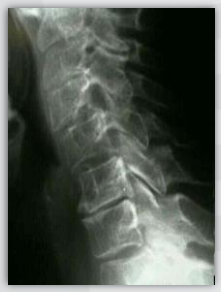
## Radiology Based Diagnosis



- Is this the extent of the patient's condition or is there something more going on? Have you proven your case?

Some DX require imaging to confirm:

- Disc conditions
- Nerve encroachment
- Fractures
- Soft tissue pathologies
- "Red Flags"

Documentation

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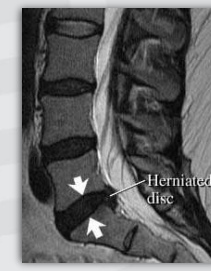
## Additional Testing

- X-rays, MR(I), CT, Bone scan, DU, NCV/EMG, or other testing may be needed to prove the need for more than a few visits
- Even if you don't need the images to treat… you may need them for the Dx




Documentation

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## The Clinical Diagnosis Process

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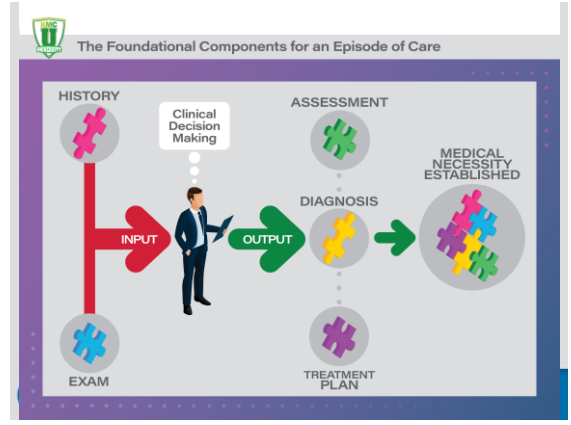


178


Define the Problem

- The job is to identify the diagnosis with the most specificity possible
- The written diagnosis will drive the treatment plan and treatment goals



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Our goal is not to teach you how to diagnose…but rather to teach you how to document your diagnosis thoughts and impressions

**The Clinical Diagnosis Process**

1. Document clear and succinct chief and additional complaints. Detail OPQRST for each. (See HPI)
2. Complete detailed patient history in reverse chronological order. Consider past symptoms, co-morbidities, and other indicators.
3. Perform an examination driven by positive HPI. Only evaluate areas with causal correlation.
4. Begin to eliminate potential diagnoses based on examination findings.
5. Arrive at your final working diagnosis. Ensure that exam documentation supports your reasoning.
6. Confirm that test results link your findings to the chief compliant with conclusive evidence.
7. If Medicare, support the primary segmental dysfunction DX with a secondary, neuromusculoskeletal DX being caused by the subluxation. If non-Medicare, reverse the order.
8. Repeat the steps to diagnose other conditions, signs, or symptoms.

180

## Revisit the History

- Always look back and review the patient history for arriving at the proper diagnosis
- Providers normally begin the differential diagnosis process with the HPI (History of Present Illness) information alone


181

## Diagnosis Is Supported by a Thorough History and Physical Examination

- Examination is needed to substantiate History findings and to quantify conditions with objective data
- Use the exam to prove your Diagnosis from History
- Positive History components become ortho/neuro/palpation exams
- Negative findings also contribute to diagnosis

182


**Diagnosis Time = Doctor Thinking**

- History + Exam = Diagnosis => Treatment Plan
- Treatment plan is based on Diagnosis
- Diagnose each area of the body you are planning to treat
- Support each service being recommended with appropriate diagnosis

184

## Case Management

- Diagnosis is one of the most important keys to case management
- Severity of diagnosis codes when accurately assigned supports the duration of the recommended treatment plan
- Diagnosis is how you communicate to the payer why you are billing this care

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## Subluxation/Segmental Dysfunction Textbook Diagnosis

| Diagnosis | Comments | History Findings | Positive Examination Findings | Radiography/Special Studies | Treatment Options |
|---|---|---|---|---|---|
| Segmental Dysfunction of Cervical Spine Joints | • Should be used when chiropractic manipulation is used as Tx for any cervical spine problem/Dx.<br>• Can be primary Dx if patient is asymptomatic or patient has tenderness and no pain.<br>• Must indicate chiropractic exam findings to support Dx. | *Nonspecific* | *Palpation*—Local tenderness or other signs of subluxation<br>*Ortho*—None<br>*Neuro*—None<br>*Active ROM*—Variable restriction<br>*Passive ROM*—Endrange restriction<br>*Motion palpation*—Specific vertebral segmental restriction or symptoms produced on endrange | • Radiography not required for the diagnosis of subluxation.<br>• Radiographic biomechanical analysis may assist in treatment decisions.<br>• For specifics see radiographic guidelines. | • Chiropractic adjustive technique.<br>• Decisions regarding specifically which technique(s) is/are applied and modifications to the given approach will be directed by the primary Dx and patient's ability to tolerate pre-adjustment stresses. |

Diagnosis M99.01

No specific History required for Diagnosis

PART

X-rays support DX but are not required

Textbook treatment options are only CMT

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APPENDIX 6-2

Low Back Diagnosis Table

| Diagnosis | Comments | History Findings | Positive Examination Findings | Radiography/Special Studies | Treatment Options |
|---|---|---|---|---|---|
| Segmental dysfunction of: Thoracolumbar Joints<br>Lumbar or Lumbosacral Joints<br>SI Joint<br>Pelvis | • Should be used when chiropractic manipulation is used as Tx for any low back problem/Dx.<br>• Can be primary Dx if patient is asymptomatic or mildly symptomatic.<br>• Must indicate chiropractic exam findings to support Dx. | Nonspecific | *Palpation*—local tenderness or other signs of subluxation<br>*Ortho*—None<br>*Neuro*—None<br>*Active ROM*—Variable restriction<br>*Passive ROM*—Endrange restriction<br>*Motion palpation*—specific vertebral segmental restriction or symptoms produced on endrange | • Radiography not required for the diagnosis of subluxation.<br>• Radiographic biomechanical analysis may assist in treatment decisions.<br>• For specifics see radiographic guidelines. | • Chiropractic manipulative therapy (CMT).<br>• Decisions regarding specifically which technique(s) is/are applied and modifications to the given approach will be directed by the primary Dx and patient's ability to tolerate pre-adjustment stresses. |
| Lumbosacral Strain/Sprain<br>Sacroiliac Sprain/Strain<br>Lumbar Sprain/Strain<br>Note: sprain/strain is not synonymous with spasm or hypermobility | • Should be reserved for acute traumatic | *Trauma*—Overstretch or overcontraction Hx as acute event<br>*Radiation of pain*—Possible (referred)<br>*Pain radiation with Valsalva-type activities*—No<br>*Worse with specific ROM*—Contraction of muscle or stretch of muscle or joint | *Ortho*—None<br>*Neuro*—None<br>*Active ROM*—Pain on active ROM that contracts involved muscles<br>*Passive ROM*—Pain on endrange stretch of involved muscle or ligament | • Radiography not required for diagnosis.<br>• With significant trauma or for medlegal purposes, radiographs may be required.<br>• For specifics, see radiographic guidelines. | • Myofascial therapy.<br>• Limited orthotic support.<br>• Ergonomic advice.<br>• Preventive exercises and stretches (e.g., spinal stabilization exercises). |
| Ankylosing Spondylitis | • Dx is radiographic, directed by P.E. findings of restriction of LB ROM of gradual onset with progression. | *Onset*—Stiffness is progressive; pain is not major feature<br>*Pain radiation*—Uncommon<br>*ROM comments*—All ROM affected; stiffness alleviated by mild exercise/stretching | *Ortho*—None<br>*Neuro*—None<br>*Active & passive ROM*—Global restriction with mild endrange discomfort<br>*Motion palpation*—Possible restriction globally and at SI joint | • Radiography required for Dx.<br>• HLA-B27 not recommended due to non-specificity. | • Myofascial therapy.<br>• Physiotherapy.<br>• Daily exercises and stretches. |

(continues)

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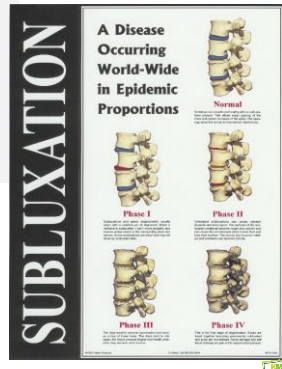
## Subluxation Philosophy

- But the subluxation is what caused the more serious condition!
- You may be philosophically right
- The 3rd party payers don't really get our philosophy
- They want the DX's that every provider outside of chiropractic uses as well

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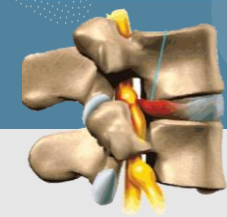
## Subluxation/Segmental Dysfunction Diagnosis

- Subluxation Diagnosis limits treatment options
- Limits time allowed to treat patient
- We need more to support medical necessity for longer duration treatment plans



VERTEBRAL SUBLUXATION –

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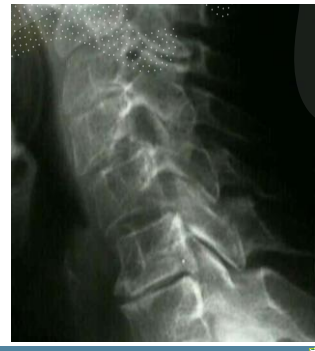
## Radiology Based Diagnosis

- Is this the extent of the patient's condition or is there something more going on?
- Some Diagnosis require imaging to confirm



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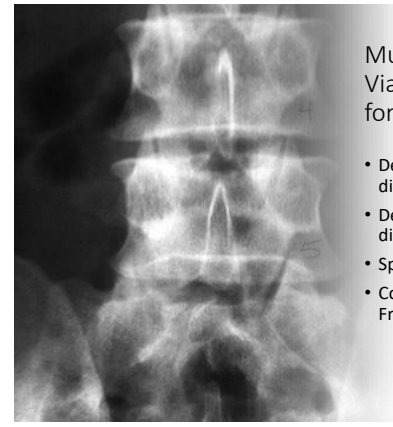


## Must Have Viable X-Ray for DX

- Degenerative joint disease
- Degenerative disc disease
- Spondylolisthesis
- Compression Fracture

191

## MRI Required for DX

- Intervertebral disc disorders
- Muscle tears
- Rotator cuff
- Other ligamentous damage or tears

192

## Not Every Diagnosis Has an ICD-10 Code

Sometimes there is no code assigned to a diagnosis, condition or syndrome the provider chooses

Common examples in Chiropractic are Upper Crossed Syndrome, Lower Crossed Syndrome, and Lumbar Facet Syndrome

While that may be the diagnosis assigned in the medical record, the closest ICD-10 code may be worded differently

It's especially important to ensure that proper coding is assigned to represent the condition which has been diagnosed

193

## Written vs. Coded Diagnosis

- These coded diagnoses are essentially the written diagnosis:
- Upper Crossed Syndrome

| | |
|---|---|
| M40.40 | Postural lordosis, site unspecified |
| M40.04 | Postural kyphosis, thoracic region |
| M62.838 | Other muscle spasm |
| R29.3 | Abnormal posture |
| M99.01 | Segmental and somatic dysfunction of cervical region |
| M99.02 | Segmental and somatic dysfunction of thoracic region |

194

**It's Just a Diagnosis, Isn't It?**

In the absence of medical records, the diagnosis is the only link to the patient's condition for an insurance company

195

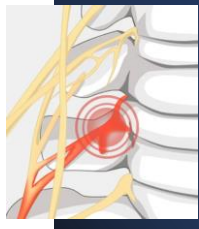
## Hierarchy Value

- Have a plan in place to maximize your diagnosis process using a hierarchy, always with the most severe listed first
- First 4 codes are sometimes all that is pulled from a claim form

196

**List Diagnosis from Most Severe to Least Severe**

1) Nerve conditions
2) Musculoskeletal conditions
3) Subluxation
4) Muscle/Posture
5) External Cause



197

## Suggested Hierarchy for Diagnosis Coding

**Position 1: Neurologic conditions**
Examples of neurological diagnoses include Radiculitis and Sciatica

**Position 2: Musculoskeletal conditions**
Examples of structural diagnoses for the spine include Degenerative Joint Disease, Spondylolisthesis, and Scoliosis

**Position 3: Subluxation/Segmental Dysfunction**
An example of a subluxation diagnosis includes Lumbar Segmental Dysfunction

**Position 4: Soft Tissue/Posture**
Examples of soft tissue diagnosis include fibromyalgia, myofascitis, and myalgia are excellent diagnoses to support manual therapy. Examples of posture diagnosis include kyphosis and hyper lordosis

198

## Suggested Hierarchy for Diagnosis Coding

**Position 5: Complicating Factors**
Examples include obesity, high blood pressure, diabetes, cancer, and other forms of co-morbidities

**Position 6: External cause, Activity, and Location Codes**
Examples are related to mechanisms of injury, like slips, trips, falls and accidents, and activity codes show what the patient was doing when injured. These are not required, but helpful, and if reported are only reported on the first claim

199

## Coding Key


**Laterality:**
1 Right
2 Left

**7th Character:**
A Initial Encounter
D Subsequent Encounter
S Sequela

**NOTE:** Not every ICD-10-CM code with a seventh character has a sixth character— or even a fifth or fourth character for that matter. The letter "x" serves as a placeholder when a code contains fewer than six characters to ensure the seventh character remains in the seventh position.

200

## Quick Tip

Guidelines for Chapter 19 injury codes state:

"7th character "A", initial encounter, is used while the patient is receiving active treatment for the condition. Examples of active treatment are... evaluation and continuing treatment by the same or a different physician."

Check with your carriers to confirm how they expect the 7th character to be used.

201

## Let's Build a Code

ICD-10 codes expand with increased specificity

**S 8 3 . 4 1 2 A**

**S** = Injuries, poisoning and certain other consequences of external causes related to single body regions

**S83** = dislocation and sprain of joints and ligaments of knee

**S83.4** = Sprain of collateral ligament of knee

**S83.41** = Sprain of medial collateral ligament of knee

**S83.412** = Sprain of medial collateral ligament of left knee

**S83.412A** = sprain of medial collateral ligament of left knee, Initial encounter

202


## Not Knowing is Not Enough

Unknowingly misrepresenting the patient's condition with improper ICD-10 coding that doesn't match the documentation is a red flag and could be interpreted as billing fraud!

203


- Diagnosis Structure is According to Payer
- Medicare wants the Subluxation Code listed as:
  - Primary Segmental Dysfunction followed by the Condition Code
  - Other Payors prefer the NMS Condition Code as Primary

204

## Medicare and Non-Medicare Payers Diagnosis Reporting Rules


**Case Example:**

Patient presents with sciatica down right leg and cervical radiculopathy

X-rays are taken and reveal disc degeneration at C5/C6 and the lower lumbar region

205

For **Medicare,** using their coupling rules, the diagnosis reporting may look like this:

1. M99.03 Lumbar Segmental Dysfunction
2. M54.41 Lumbago with sciatica down right leg
3. M99.01 Cervical Segmental Dysfunction
4. M54.12 Cervical radiculopathy
5. M99.04 Pelvic Segmental Dysfunction
6. M54.36 Disc degeneration lower lumbar
7. M50.322 Disc degeneration C5/C6
8. M62.830 Muscle spasm of the back

206

For most non-Medicare payers

List the diagnosis is descending order of severity

1. M54.41 Lumbago with sciatica down right leg
2. M54.12 Cervical radiculopathy
3. M54.36 Disc degeneration lower lumbar
4. M50.322 Disc degeneration C5/C6
5. M99.03 Lumbar Segmental Dysfunction
6. M99.04 Pelvic Segmental Dysfunction
7. M99.01 Cervical Segmental Dysfunction
8. M62.830 Muscle spasm of the back

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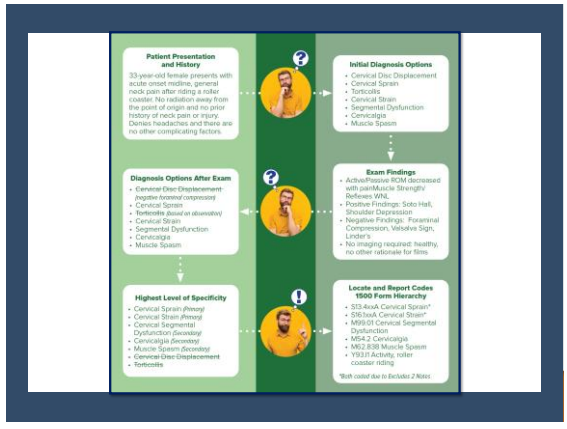


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209


- Diagnosis is a critical part of your Medical record
- Must be documented within initial visit documentation of the episode of care
- This is the single most important place for the diagnosis to be recorded for insured or self-pay patients

210

**Remember!**

**The best reasons to choose a certain diagnosis are based on:**

- **History**
- **Examination**
- **Assessment**
- **Additional testing indicated**
- **Best describes the patient's condition**
- **Best to report the condition**

211

## What Good Looks Like

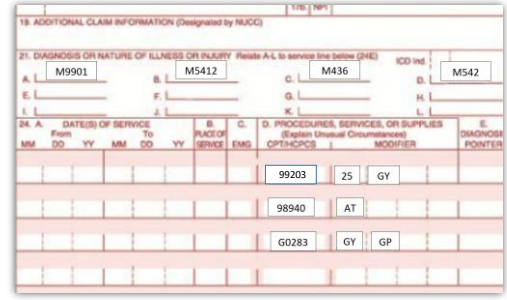
**DIAGNOSIS:**

Upon consideration of the information available I have diagnosed Kathy with: (M5412) Radiculopathy, cervical region, (M99.01) Seg and somatic dysf of cervical reg, (M99.02) Segmental and somatic dysf of thoracic region, (M62.830) Muscle spasm of the back

Compensatory Diagnosis: (M99.03) Segmental and somatic dysf of lumbar region, (M99.05) Segmental and somatic dysf of pelvic region

212

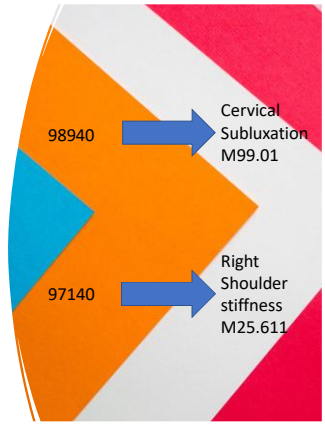
## Medicare Example




214

## Diagnosis Pointing for 59 modifier

- When a service is considered mutually exclusive of another service
- Utilize diagnosis pointing to demonstrate to the payer that a separate service was performed in a separate region/area

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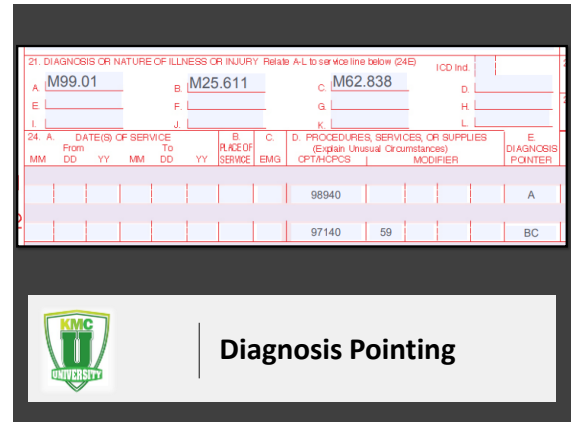



216

## Diagnosis is Dynamic

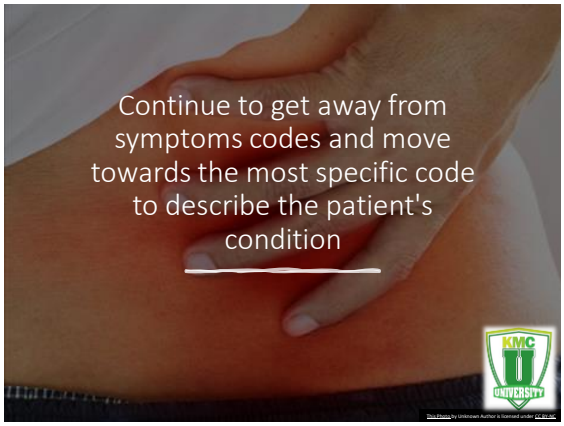
- Realize that the diagnosis is a definition of what is going on with the patient now
- When you do your periodic re-evaluations, you may find that you need to update your diagnosis to describe the patient's present circumstance

217

## Applying What You Learned

- Look at your diagnosis process:
  - Does your exam quantify your history and lead to diagnosis to support your treatment plan?
- Look at your most common Diagnosis codes and compare them to the Diagnosis criteria required


218




219

## Yearly Updates

- The ICD-10 code set will be updated ongoingly
- New codes go into effect each October 1
- It's critical to stay informed about changes to the codes or wording
- Update billing and computer systems accordingly.


220


221


222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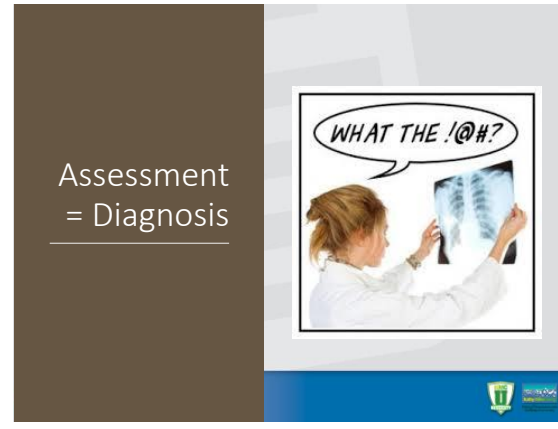


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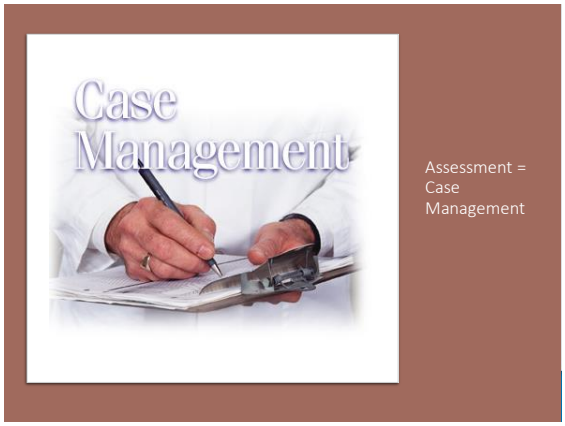


226

## Job 3: Doctor Thinking

- This is initial assessment (S+O)
- H + E = D => Tx Plan
- Diagnosis for each region you plan to treat
- Treatment plan is obvious based on DX
- DX and plan for each component service

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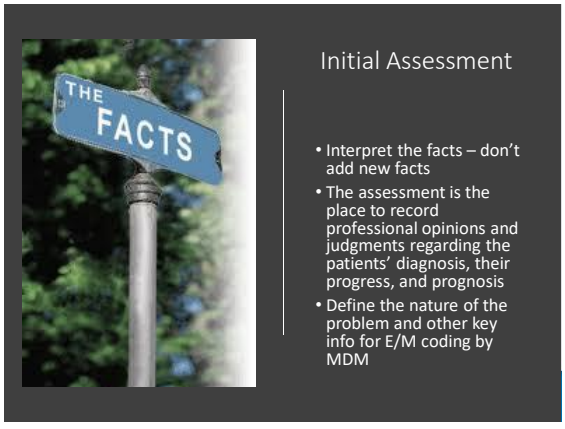


## Initial Assessment

- Interpret the facts – don't add new facts
- The assessment is the place to record professional opinions and judgments regarding the patients' diagnosis, their progress, and prognosis
- Define the nature of the problem and other key info for E/M coding by MDM

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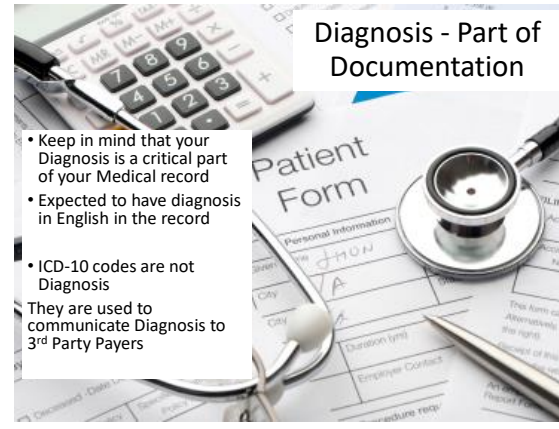


## Diagnosis - Part of Documentation

- Keep in mind that your Diagnosis is a critical part of your Medical record
- Expected to have diagnosis in English in the record
- ICD-10 codes are not Diagnosis

They are used to communicate Diagnosis to 3rd Party Payers

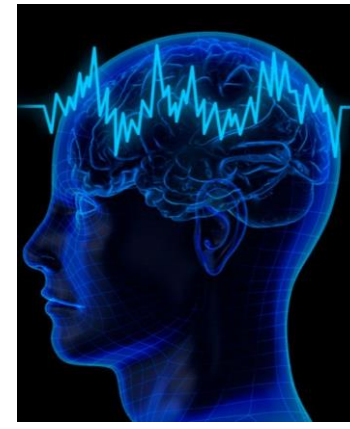
229

## Provide Appropriate Rationale

230

## Tell Us What You're Thinking

- Why are the tests being ordered?
- Why did you decide to do what you did?
- What's between your ears must appear in the documentation
- X-rays, labs, other diagnostic tests, referrals, and DME



231

## Sample Uncomplicated Assessment

I have diagnosed Fred with an acute, uncomplicated injury from his slip and fall. He has no known risks that would complicate his recovery, and there is low risk from gentle, conservative chiropractic care.

Fred is in good health and is expected to make good progress and recovery with few anticipated residuals. There are no complicating factors to consider and no specific contraindications to chiropractic treatment.

Based on his history and examination, it is reasonable to believe that barring any unforeseen circumstances, his recovery will probably take about the same length of time as an average patient with an uncomplicated musculoskeletal case.

Documentation

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## The Treatment Plan Lays the Foundation in the Initial Visit of Episode

234


235

## Medicare Documentation Guidelines

**Initial Visit**

- History
- Description of Present Illness - including functional deficit(s)
- Proof of Subluxation
  - PART or X-ray
- Physical Exam (PART)
- Assessment & Diagnosis
  - 1° Subluxation
  - 2nd Condition
- Treatment Plan
- Date of initial treatment

**Subsequent Visits**

- History
- Review of chief complaint
- Physical Exam (PART)
- Document daily treatment
- Progress related to treatment goals/plan (Assessment)

Documentation

236


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## Episodes of Care


Documentation

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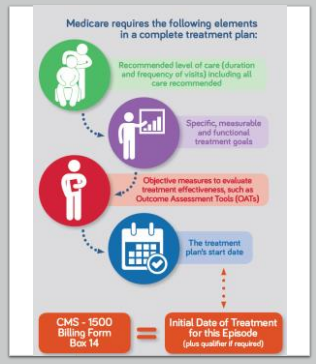
## Treatment Plan

- Your treatment plan is your pre-determined plan of action.
- It will take into consideration the tissue specific issues defined in your patient work-up and diagnosis
- Soft-tissue diagnosis and soft-tissue targeted treatment




Documentation

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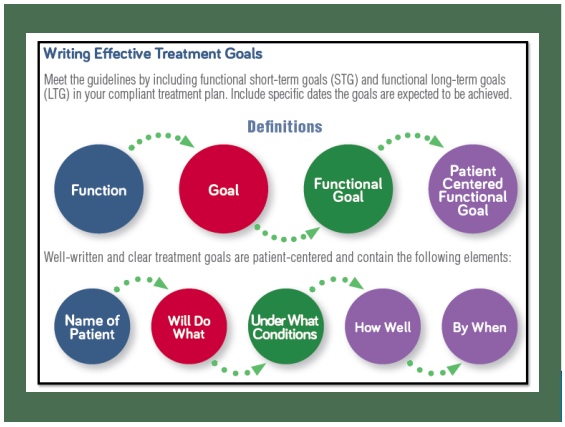
## Meet the Requirements

- Frequency and duration
- Treatment goals for each region/treatment to include long term goal
- An evaluation of treatment effectiveness measurement
- Date of the plan

240




241

## Use OATs to Help with Your Goal Writing

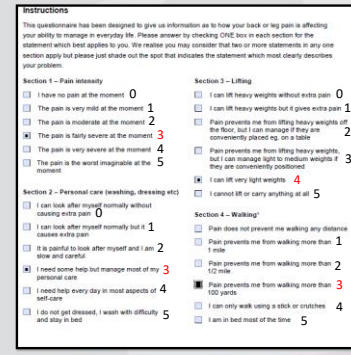
- Use OATs to assist with identifying functional limitations
- Use mnemonics as cues to assist with including all necessary elements
- Goals should ALWAYS be functional in nature


242

## One More Great Reason!

- OATs are a great education opportunity to show patients their progress.
- Patients forget how bad off they were when they first begin care; the OAT is a great way to remind them of how they have changed through a course of care

243




Total of 13 Points

Documentation

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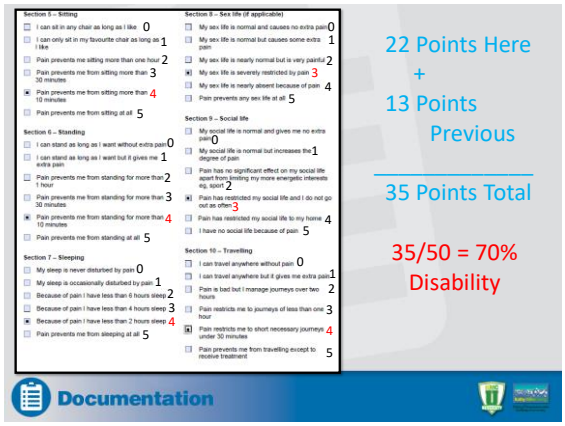


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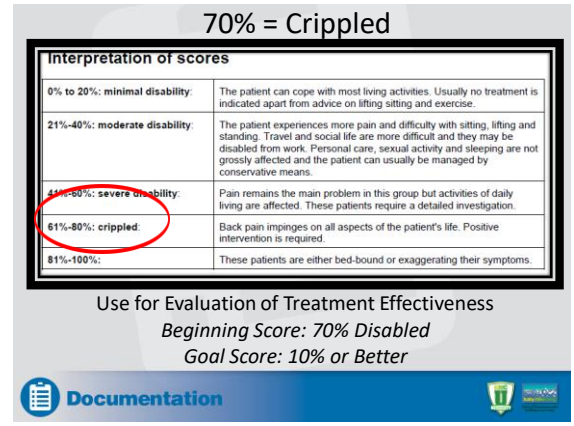


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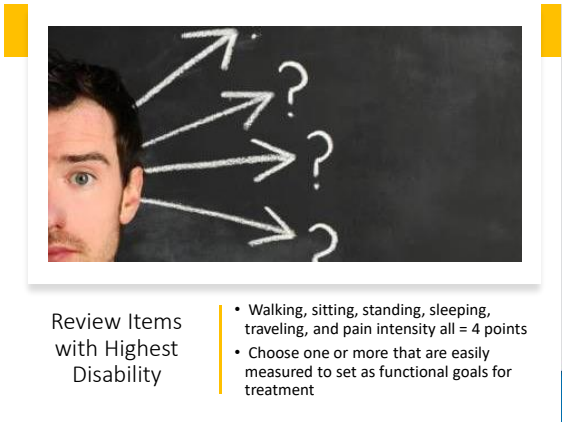

Review Items with Highest Disability

- Walking, sitting, standing, sleeping, traveling, and pain intensity all = 4 points
- Choose one or more that are easily measured to set as functional goals for treatment

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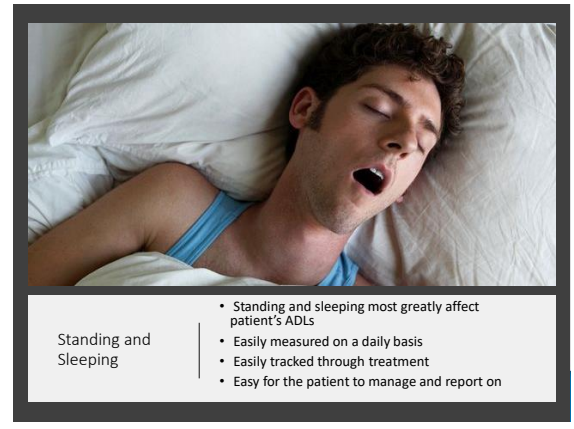


Standing and Sleeping

- Standing and sleeping most greatly affect patient's ADLs
- Easily measured on a daily basis
- Easily tracked through treatment
- Easy for the patient to manage and report on

248

Address Current and Previous Functional Limitations

- Address the patient's abilities before this incident
- Use for comparison to current limitations
- Assists with measurable aspect of goals
- Make goal realistic to patient's previous abilities

249

For Example…

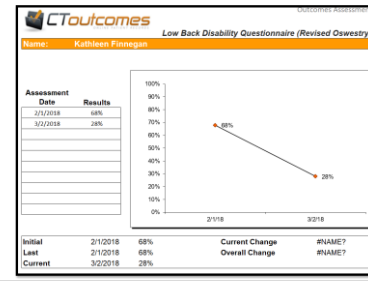
- STG: Mary will sleep for 4 hours without interruption by 3/4/15
  - This increases by one unit in the "Sleeping" category
- LTG: Mary will sleep for up to 8 hours without interruption by 5/15/15, which is her level of function prior to this slip and fall incident
  - This increases the function up to the "zero" limitation level in the "Sleeping" category

250

Track Progress

- OATs should be repeated every 30 days or upon discharge
- Per Yeomans, 30% improvement denotes "significant" improvement
- If patient is unable to reach goal, that creates new baseline "normal"

251




Report on Progress and Results

- Demonstrate how the OAT contributed to decision making
- If it gets worse on evaluation, take action
- Always "introduce" into the health record

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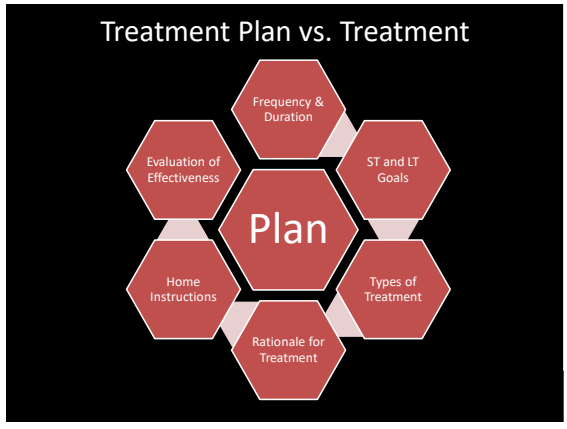


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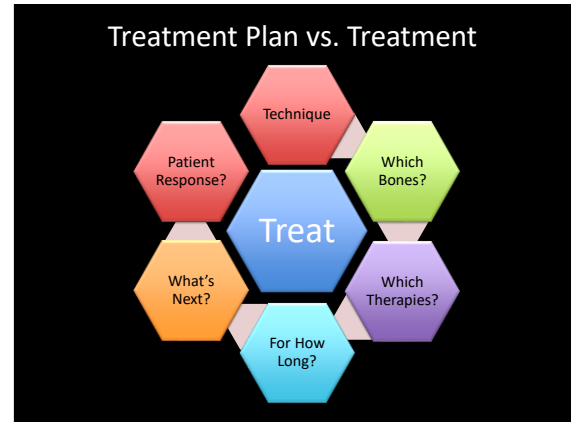


254

## Patient Wasn't Treated

- Patient was advised in using ice at home
- Instructed to return for treatment
- If the patient was treated TODAY then SOAP should be added below the TX plan!!

Documentation

255

This Visit Must Include "P" of SOAP if you Treat!

**Today's Treatment:**
- **Primary Treatment:** Diversified, Activator and Gonstead- Chiropractic Manipulative Treatment (CMT) to the C3, C4, L3 and L4 spinal level(s). Right Sacrum
- Compensatory adjustment(s) at level(s): T5, T6, T7 and right pelvis
- **Therapeutic Exercise:** Isometric ROM and stretching, neck, upper back-passive assisted, using hand and light theraband-17 minutes; abdominal hollowing, cat arch stretching for lower back-7 minutes; wall angels and mid-back stretching-rhomboids-8 minutes TOTAL TIME: 32 minutes
- **Advised**
  - *Tx Effect:* Treatment rendered without incident
  - *Next Visit:* continue with treatment plan as scheduled

Treatment is different than treatment plan. On E/M visits where you are establishing a treatment plan, if you execute treatment the same day, don't forget to list it.

Documentation

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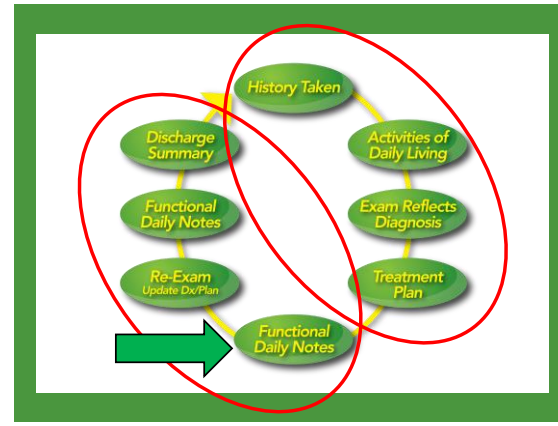
The Routine Office Visit (ROV) Defined

258

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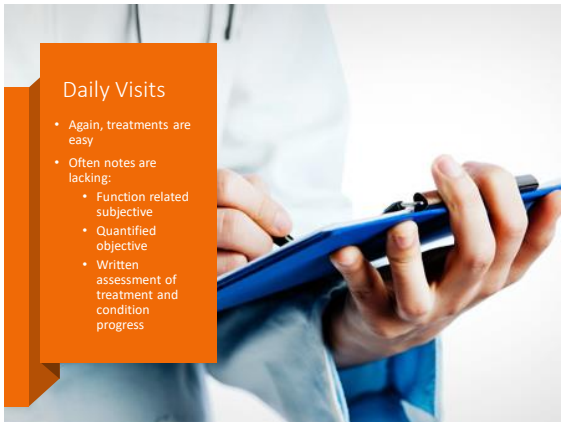
261

## Job 4: Doctor Fixing

- Clarify and execute your plan
- Goals are associated with the plan
- Medical necessity is clear
- Code the correct treatment that you chose

262



## Daily Visits

- Again, treatments are easy
- Often notes are lacking:
  - Function related subjective
  - Quantified objective
  - Written assessment of treatment and condition progress

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## Medicare Documentation Guidelines

**Initial Visit**

- History
- Description of Present Illness - including functional deficit(s)
- Proof of Subluxation
  - PART or X-ray
- Physical Exam (PART)
- Assessment &Diagnosis
  - 1° Subluxation
  - 2nd Condition
- Treatment Plan
- Date of initial treatment

**Subsequent Visits**

- History
- Review of chief complaint
- Physical Exam (PART)
- Document daily treatment
- Progress related to treatment goals/plan (Assessment)

264

**S=SUBJECTIVE**
- Clients' complaints in their own words, use an analog scale

**O=OBJECTIVE**
- Observations made about the client, such as: posture, patterns, movement, weakness, level of tension in the tissues, spasms in muscles, joint movement, color/temperature of skin and breathing patterns

**A=ASSESSMENT**
- Includes results of the treatment, reanalysis of posture and range of motion

**P=PLAN**
- Suggest a treatment frequency or establish a set amount of visits based on similar cases, include any self care instructions, establish a re-evaluation time

S O A P N O T E

Documentation

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## DOCUMENTATION

**S + O = A → P and PART**

How do the topics fit into our daily documentation?

| SOAP | PART |
|---|---|
| • Documentation system for patient encounters<br>• Best for daily visits | • Required documentation for subluxation/segmental joint dysfunction<br>• Many providers believe that PART is enough |

Documentation

266

## Subjective - P=Pain or Tenderness

| | | | |
|---|---|---|---|
| Observed facial expressions of pain or discomfort | Antalgic postures and movements | Grooming deficiencies that could be due to limitations caused by pain | Mood |
| Overt pain behaviors | Pain scales/Pain diagrams and drawings | Functional questionnaires | Pain resulting from static palpation |
| Pain resulting from motion palpation | Pain reported during regional and or segmental range of motion tests | Pain reported during physical, orthopedic, neurological, and/or chiropractic examination procedures | Algometry |

Documentation

267

## Medicare's Routine Office Visit "Subjective" History Requirements

**History (an interval history sufficient to support continuing need; document substantive changes)**
- Review of complaint(s)
- Changes since last visit
- System review if relevant

268

B. Established Patient Visit:
1. Subjective Complaint: The patient's description of complaints should be recorded at each visit indicating improvement, worsening, or no change.

## Colorado's Minimal ROV Subjective Requirements

269

Daily Documentation Must Include Patients' Self-Appraisals

- Know your functional deficits in order to focus your conversation on how they have changed.
  - Better
  - Worse
  - Same
  - Measurable

270

## Daily Subjective Documentation Must Include Patients' Self-Appraisals

- Examples:
  - Better - Ability to brush hair in the morning without thumb and index finger tingling 50% of the time
  - Worse - Increased difficulty putting on socks and now requires assistance from a family member
  - Same - No change in ability to walk one block without increased pain

271

## Best Practices for Gathering Functional Self-Assessment

"Mrs. Klaus, your walking really seems improved. When you first came in you were able to walk about 10 feet without that sharp pain… How far are you able to walk today without the pain coming back?"

272

## Best Practices for Gathering Functional Self-Assessment

"I understand you feel your back pain is the same as when you first came in. At that time you could only stand to do dishes for 10 minutes, and spasms would start … How long can you stand to wash dishes now?"

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## Good Subjective Examples

Patient reports cervical pain that is dull and rated at 3/10. She reports there has been no change in her overall neck pain since the last visit but she is now able to sleep 7-8 hours a night with 3 hours uninterrupted by pain.

Since the last visit the patient has decreased in sharp low back pain from a 4/10 to 2/10. He says "It didn't hurt to ride my bike here today." When asked how long of a drive that was, he indicated that it was about a 30 minutes.

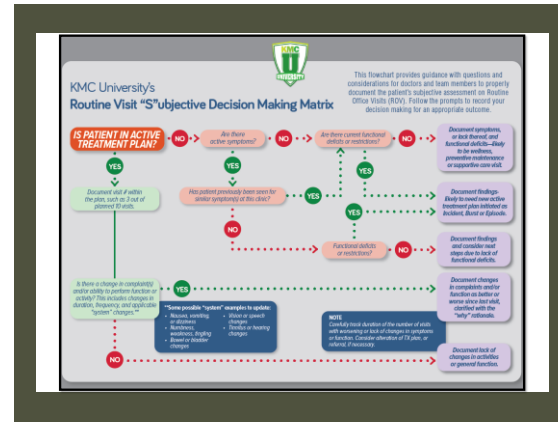
Documentation

274

## Master Internal Systems that can Streamline this Process

- Team member driven documentation
- They gather relevant data
- You review out of sight of the patient then…
- You lead the conversation
- Save as much as an hour a day

275



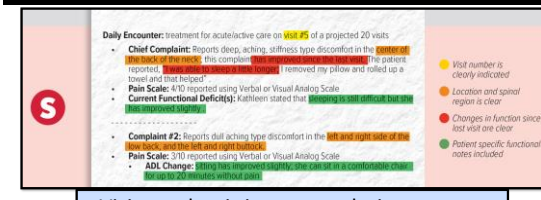

276

## Consider Subjective For Each Condition if Appropriate


- Focus in on each area you plan to treat
- Set yourself up for good transition to the objective section of your note
- Remember: "Changes Since Last Visit"—it's probably an episode
- Document this moment in time

277

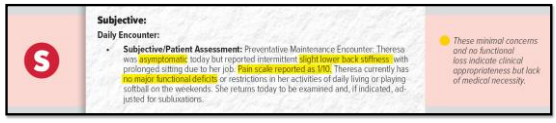
## Active Treatment Routine Office Visit (ROV) Subjective




- Visit number is important during an episode
- If more than one complaint, list all detail
- Keep the focus on function as much as possible

278

## Preventive Maintenance Visit Subjective




- Record the patient's subjective reason for the visit
- It's OK to only discuss pain, but nod to the functional deficits if they exist
- Visit Number is less important in this note

279

## Wellness Visit Subjective


- Note that it's a wellness visit, per your definition
- It's OK to only discuss pain if it exists, and to note that the patient is asymptomatic
- Visit Number is less important in this note

280

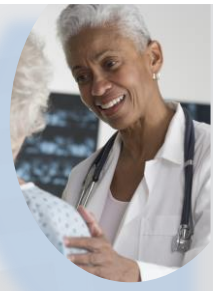
## Objective = ART

- Quantifies the Subjective
- Daily physical exam
- Gathers data for treatment
- Identify the exact segments to be treated

**S** (P)+ **O** (ART)= **A**

- **How** has the patient responded to treatment?
- **Why** do they need more care?
- Are they meeting goals?

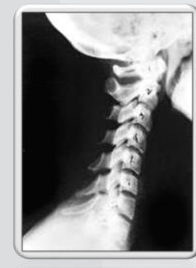
N/C, Guarded, Improving is not enough!



Documentation

281

## A= Asymmetry or Misalignment

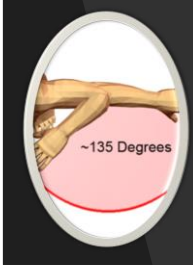


- Observable region asymmetry (posture or scoliosis screening)
- Observed local asymmetry (static palpation)
- Antalgic posture
- Gait abnormalities
- Functional or anatomical leg length discrepancies
- Muscle atrophy and asymmetry.

Documentation

282

R= Range of Motion Abormality



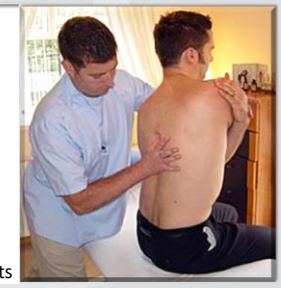

- Active ROM (observed and estimated)
- Passive ROM
- Resisted ROM
- Segmental motion palpation
- Joint fixation (hypomobility)
- Joint laxity (hypermobility)
- Joint crepitus
- ROM measurements

283

283

## T=Tissue Tone Changes

- Observable hypertonicity, spasm, hypotonicity, and atrophy
- Fasciculations
- Edema
- Bruising, discoloration
- Heat
- Muscle-tendon crepitus
- Muscle weakness
- Heat measuring instruments



Documentation

284

## O = ART Data Gathering

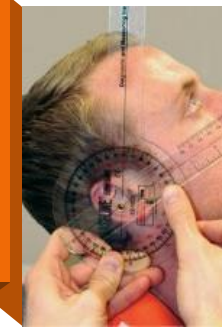
What do you see, palpate, and/or observe about the patient before treatment

- Asymmetry (posture, ortho findings)
- Range-of-motion (limitations or mobility)
- Tissue tone (Spasm, listings, inflammation)

285

## O = ART Data Gathering

- Objective measures can be quantified
- ROM in °'s
- Soft tissue is rated by severity (minimal to severe)
- Asymmetry of posture to cm or mm
- % of impairment or improvement when possible



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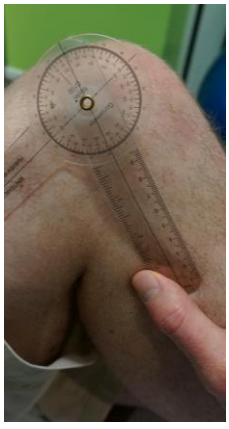


## O = ART Gathering

- Left foot flare decreased during perambulation by 10° since last visit. Patient is now 95% of WNL
- Cervical Right Lateral Flexion has improved 10% since last visit resulting in an increase in 5°
- Bilateral trapezius spasm has decreased from moderate to mild since last visit.

287

## Frequency of OATS

- Required to be performed every 30 days!
- Must be a standardized tool-- are many to choose from
- Use the same OAT for the same patient
- Excellent for Evaluation of TX Effectiveness

289


290

Continue Care? Or Discharge?

- Assessment findings justify continued care or discharge
- Final exam should verify maximum therapeutic benefits has been achieved

291

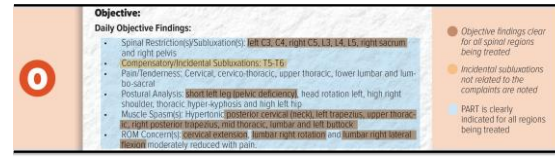
## When Should You Refer Out

- Certain situations indicate that you should not treat the patient
  - Patient's condition is not responding to the treatment rendered, when all reasonable alternative chiropractic methods have been exhausted
  - The patient's condition is worsening with treatment
  - The patient experiences a medical emergency

Documentation

292

## Active Treatment Routine Office Visit (ROV) Objective




- Parts of PART can be a simple basis for objective
- Separate incidental subluxations from active
- Include what's necessary to justify and validate today's treatment—muscle related if performing muscle work

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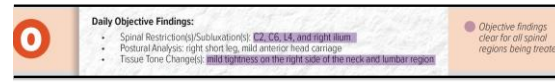
## Preventive Maintenance Visit Objective


- There can be objective findings and it's still considered preventive maintenance
- Record findings that align with your technique
- Spinal restrictions listed warrant adjustment of those segments

294

## Wellness Visit Objective




- There can be objective findings and still considered wellness treatment
- Record findings that align with your technique
- Spinal restrictions listed warrant adjustment of those segments
- The intent of the visit and subjective documentation helps clarify

295

## Subsequent Visit: Assessment

**Documentation needs to show what the doctor is thinking:**

- Treatment effectiveness
- Assessment of change since last visit

**How and Why**

- What is the progress towards the functional goals?

Documentation

296

## Paint the Picture of Progress Toward Goals

- Can be unchanged or even regressing
- Must be quantitative
- Function is the key
- Paint the picture
- Don't leave the story half complete

Documentation

297

## The Purpose of Assessment in the ROV Note

- To tie the note together
- To provide context of the findings in S and O
- To carry the thread from visit to visit to show progress or lack thereof

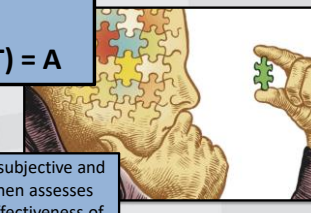
298

## From PART to Assessment

**P + ART = Assessment**

or

**S (P) + O (ART) = A**



Doctor considers today's subjective and objective findings and then assesses what they mean to the effectiveness of the treatment

Documentation

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## Assessment of Patient's Assessment

- Patient's assessment of their condition
  - Compare ART of the visit against the patient's statements
  - How much do their statements relates to the effectiveness of treatment?
  - Quantify with Objective findings
  - Be ready to explain in assessment

300

## Assessment of Patient's Assessment

Examples:

- The patient indicates that her pain is unchanged but upon palpation there is less spasm than the previous visit in her low back. I believe that her condition is improving.
- The patient's opinion that her ability to walk 20 ft without increased pain in her knee is questionable because I observed that she had difficulty walking to the 15-20 feet from the reception room to the treatment room. She still has room for functional improvement.

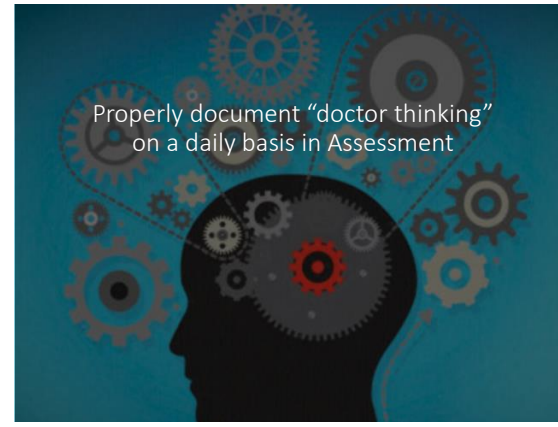
301

## Assessment of ART

The slight improvement (approx. 2-3°) in her low back ROM indicates that her condition is improving

Increased muscle guarding in the cervical spine after the last CMT indicates that the patient is not responding well to diversified adjusting. Change technique to high velocity, low amplitude thrust for the duration of the plan of care.

302




303

## Best Practices for Defining your Doctor's Assessment

- Remember it is all about Function, Function, FUNCTION
- Identify HOW the patient has improved
- Identify WHY they need continued care
- That is Medical Necessity by definition!

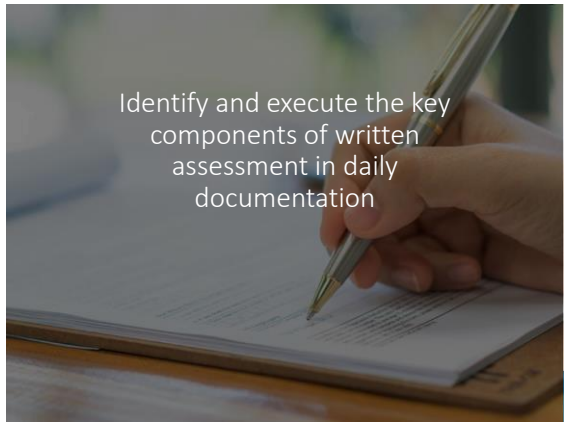
304

## Resolved and Stable

**Daily Assessment:** It's my opinion that Mary has reached maximum medical improvement for this condition, as evidenced in today's subjective and objective evaluation.
- *Current Functional Ability:* Mary can currently lift, pull and push up to 50 pounds without increased pain, residuals, or exacerbation of her condition. The pain no longer shoots down her leg. She has met the short term goals through the treatment episode, and has now met the long term goal of moving 50 pounds of weight with more stability, within 30 days of the initiation of this most recent treatment plan.
- *Determination of Care:* No additional active treatment is necessary for this condition, since her goals have been met and she is stable at this time. She will be discharged from active treatment today.

Documentation

313




314

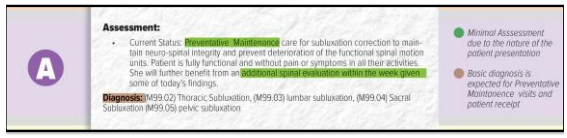
## Assessment as Case Management

- The following are examples of assessments that show the proper way to document through a course of treatment
- A real story is told of how the patient is getting better
- No auditor could question the effectiveness of the doctor's treatment or his management of the condition

Documentation

315

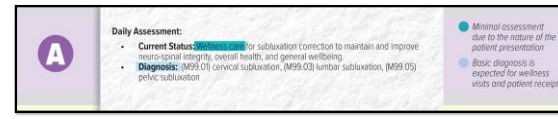
## Preventive Maintenance Visit Assessment




- Record the current status and elaborate if necessary.
- Maintenance can look different from visit to visit, so detail here is helpful
- Include the diagnosis here, as it may be the only place it appears

321

## Wellness Visit Assessment




- Note that it's a wellness visit, per your definition
- Asymptomatic assessment is perfectly fine given the lack of findings beyond subluxation
- Consider using diagnosis in this section since it may be the only place it shows up

322

## Treatment "Plan"

**S** (P) + **O** (ART) = **A** → **P**

**Treatment is a result of:**

- S+O findings
- Your assessment that TX will help condition

Documentation

323

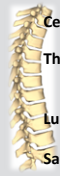
## Subsequent Visit: Treatment

- **CMT**
  - List spinal/vertebral areas adjusted that are MN
  - Include secondary areas of compensation that were treated
  - Include technique
  - Manual manipulation
  - Can include handheld device with manual force
  - How did patient handle the treatment
- **Passive/Active therapies**
  - Document what was done, why it was done, and how it affected the patient

Documentation

324

## Spinal Regions



**Cervical:** Atlanto-Occipital to C7

**Thoracic:** T1 through T12 including posterior ribs

**Lumbar:** L1 through L5

**Sacral:** sacrum including sacrococcygeal junction

**Pelvic:** SI joints and other pelvic articulations

## Extra-Spinal Regions

**Head:** includes TMJ

**Upper extremities:** shoulder, arm, elbow, wrist, and hand

**Lower extremities:** hip, leg, knee, ankle, and foot

**Rib cage:** anterior rib cage

**Abdomen:** soft tissue of the abdomen

Documentation

325

## Tell Them What You Did

**Today's Treatment:**
**- Primary Treatment:** Diversified, Activator and Gonstead- Chiropractic Manipulative Treatment (CMT) to the C3, C4, C5, left T1 and left T2 spinal level(s).
- Compensatory adjustment(s) at level(s): right L4, right L5, right sacrum and right pelvis
- Extraspinal region(s) adjustment: right TMJ
**- Supportive Therapy** to optimize treatment effectiveness the following therapy(s) were performed:
**- As per treatment plan - Hot Pack:** hot moist pack applied to posterior cervical (neck) region(s) for 15 minutes,
**- As per treatment plan - EMS Unattended** low volt EMS applied to left side of neck and right side of neck region(s) for 15 minutes.
**- Advised**
- *TX Effect:* Treatment rendered without incident and responding as expected.
- *Next Visit:* continue with treatment plan as scheduled

Documentation

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## Spinal Regions

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Atlanto-Occipital to C7
**Thoracic:**
T1 through T12
including posterior ribs
**Lumbar:**
L1 through L5
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anterior rib cage
**Abdomen:**
soft tissue of the abdomen

Documentation

327

Create "The End" to Every Story with Proper Patient Discharge

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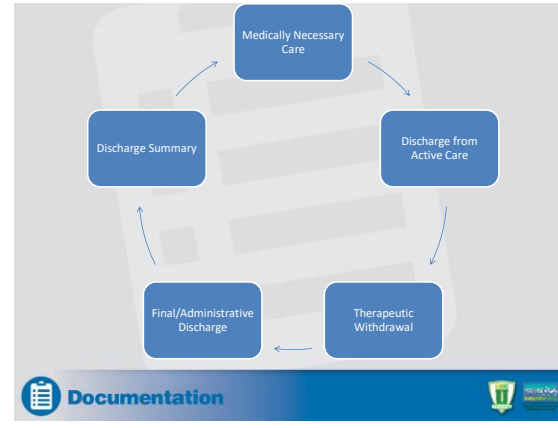



330

Continue Care? Or Discharge?

- Assessment findings justify continued care or discharge
- Final exam should verify maximum therapeutic benefits has been achieved

331

## When Should You Refer Out

- Certain situations indicate that you should not treat the patient
  - Patient's condition is not responding to the treatment rendered, when all reasonable alternative chiropractic methods have been exhausted
  - The patient's condition is worsening with treatment
  - The patient experiences a medical emergency

Documentation

332


## Maintenance or Wellness Care vs. PRN

- Discharge to something
- Know that the episode of care is complete
- Reoccurrence vs. Exacerbation
- Next active episode…begin again!

333

## When to Release from Active Care

- At scheduled re-evaluations review patient's progress towards:
  - ADL goals
  - Functional goals
  - Symptom free goals
- Within active treatment if the results warrant
  - Reschedule evaluation earlier

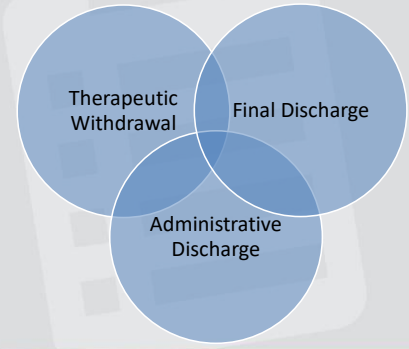
Documentation

334

## When to Release from Care

- Per CCGPP: When the patient arrives at Final Plateau (maximum therapeutic benefit)
- Complete or partial resolution of the condition and all reasonable treatment and diagnostic studies have been provided
- Patient is unlikely to improve further

335




Documentation

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## Therapeutic Withdrawal

- Strategically weaning the patient off of medically necessary care to determine if they can maintain the therapeutic goals of treatment
- Final step before patient can begin maintenance care

Like a game of Jenga… Making sure the pieces you moved are where you want them before removing your hands.

Documentation

337

## Types of Therapeutic Withdrawal

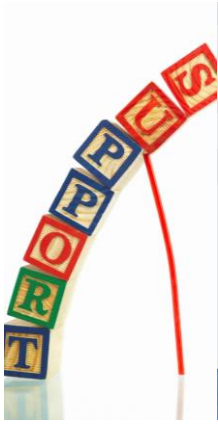
- Gradual Withdrawal
  - Where the patient's care is tapered off

| Times a Week | # of Weeks |
|---|---|
| 3 | 2 |
| 2 | 2 |
| 1 | 2 |
| 1 every other week | 4 |
| Total = 14 visits | |

- Abrupt Withdrawal
  - Patient instructed to return if the symptoms recur
  - Patient is scheduled for an evaluation at a later date to determine if there is any regression
  - Tends to be the typical MD approach

Documentation

338




## Therapeutic Withdrawal

CCGPP (Clinical Compass)

- Therapeutic withdrawal (TW) is included as **proper** case management
- Without TW
  - There is no way to determine the stability of the spine
  - Determine if a patient require on going care

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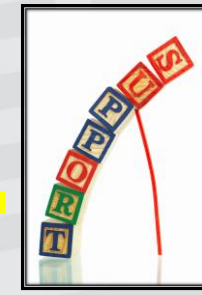
## Therapeutic Withdrawal

- The Mercy Guidelines
  "Periodic trials of therapeutic withdrawal fail to sustain previous therapeutic gains that would otherwise progressively deteriorate"
- Utilization review standpoint
  - The proof that a patient cannot sustain therapeutic gains can only be demonstrated through periodic withdrawals from care, along with detailed documentation which clearly supports a subsequent regression in patient status




Documentation

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## Define Therapeutic Withdrawal for Your Protocols

When functional status has remained stable under care and further improvement is not expected or withdrawal of care results in documentable deterioration, additional care may be necessary for the goals of supporting the patient's highest achievable level of function, minimizing or controlling pain, stabilizing injured or weakened areas, improving activities of daily living, reducing reliance on medications, minimizing exacerbation frequency or duration, minimizing further disability, or keeping the patient employed and/or active.


Documentation

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## Therapeutic Withdrawal


**Maintenance**

- The patient is **MAINTAINING THE CURRENT STATE** and not expected to improve.

**Therapeutic Withdrawal**

- The doctor is not 100% convinced that the patient will not relapse if active care is discontinued. **WE'RE TESTING TO SEE IF STABILITY CAN BE MAINTAINED.**
- (A short term trial)

Documentation

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## Beginning Therapeutic Withdrawal- Sample

**Assessment:**

Patient has met the outlined goal of being able to sleep 6-8 uninterrupted hours a night without awaking due to neck pain. It is my clinical opinion that a trial therapeutic withdrawal of treatment is warranted at this time. The patient will return in 2 weeks to determine if additional treatment options are warranted. At that time, I will either alter the treatment plan according to exam findings or release the patient into maintenance care.

Documentation

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## Sample Assessment- Therapeutic Withdrawal

Mrs. Murphy's average pain level is a 5/10 when she stands for about an hour. She is not likely going to be able to stand more than that or have a lower pain level. (Patient returns a month later for care)

**or**

Mrs. Murphy can now stand for one hour with an average pain level of 5/10. Even though it is unlikely that she will ever have a lower pain level or more than one hour of time standing without increased pain because of her age and DDD, I feel that before releasing her into maintenance care a period of therapeutic withdrawal is indicated after today's treatment. I will reassess her condition and ADL's in a month to determine if the patient can maintain her current ADLs and associated pain levels.

Documentation

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Final Discharge


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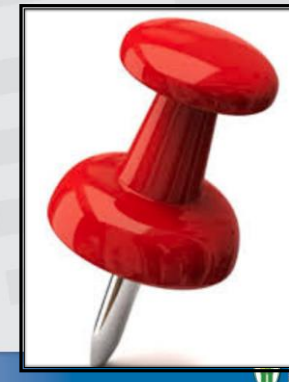
You Decide When to Put a Pin In It!



348

## Clinical Discharge

- Releasing from Medically Necessary Care
  - The patient doesn't need treatment to improve function anymore
  - Release them so they can fly on their own
  - Be the place they can maintain safety
  - Discharge puts a "pin" in this active episode

Documentation

349

When to Release from Care

CCGPP
- Arrive at Final Plateau (maximum therapeutic benefit)
- Complete or partial resolution of the condition and all reasonable treatment and diagnostic studies have been provided
- Patient is unlikely to improve further


350

## Discharge Summary

- Include:
  - Conditions treated
  - Initial treatment date
  - Date of discharge
  - # of Visits
  - Services provided
  - DME/orthotics RX'ed
  - Recap initial exam findings
  - Recap radiology and/or lab testing
  - Status of patient at discharge
  - Your assessment of patient's treatment
  - Recommendation for future care


351

## Final Discharge Checklist

- You've finished a course(s) of treatment
- The patient has met or is not likely to move closer to reaching goals
- You have effectively attempted therapeutic withdrawal or documented why it is not indicated
- The patient has been given educational and self management tools about his/her condition
- Written discharge is placed in chart

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Administrative Discharge


umentation

359

## Administrative Discharge

**The Patient May Fire You**

Patient self-discharges or simply doesn't return for recommended care

- Personal issues
- Financial issues
- "Feels better"
- Too busy
- Not improving and not telling you

**You May Fire the Patient**

Releasing the patient for non-compliance or other reason not directly related to care

- Missing appointments
- Dictating Care
- Not doing "homework"
- Make referral to other provider

Documentation

360

## When the Patient Drops Out

- Have a system for missed appointment follow-up
  - 3 phone calls
  - Last call from the doctor
  - Letter or something in writing
  - Notes in the patient's health record
- Close the case in your documentation
  - Letter to patient outlines your attempts
  - Formally dismissing
  - Available for any additional care you feel you need
  - Closing current case
  - Happy to refer to other providers if necessary

Documentation

361

## What If?

- All records will be collected in accident cases
- Any "open" cases could bode poorly for the patient
- Can also be a reason to encourage patient to come for one more discharge visit

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## Applying What You Learned

- Review your documentation, or have someone else do it
- Evaluate your active vs. maintenance status
- Evaluate your internal compliance program and make plans to update

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