




Coding, Billing and Compliance in Chiropractic...Made Easy


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Know the Messenger





- February 3, 1983
- My first day as a chiropractic patient
- My first day as a chiropractic employee

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Good Documentation Tells the Story!


4

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



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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 for Active Treatment

- 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?

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Your Patient's Flow Under Care



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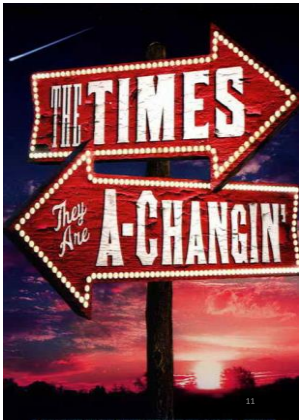
This Now Becomes the Story You May Have to Tell



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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"



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Your Passion is Also a Regulated Business

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Parts of an Effective Office Compliance Program

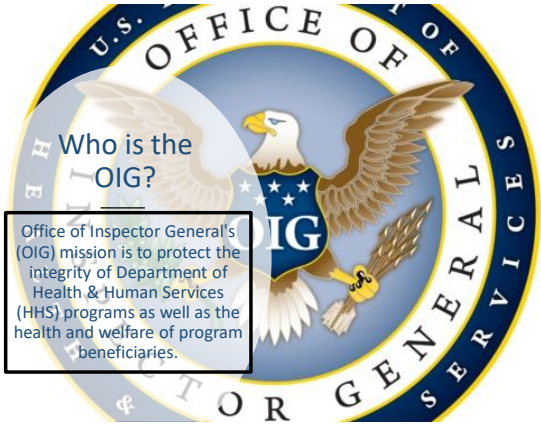
- CMS/Medicare
- OIG compliance
- HIPAA
- OSHA
- CLIA
- Anti-Kickback Laws
- Stark Laws
- State laws
- Employment Laws



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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

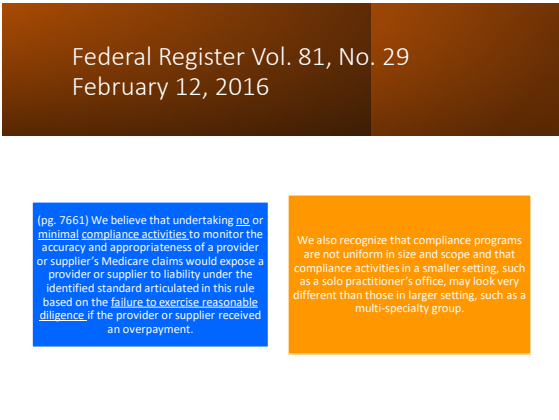


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Federal Register Vol. 81, No. 29
February 12, 2016

(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

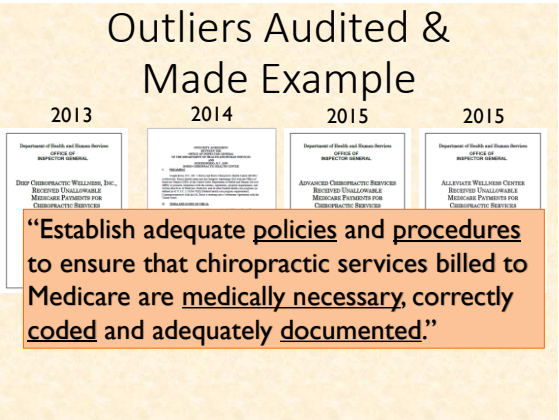
Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

DEEP CHIROPRACTIC WILLOUGH, DALLAS, RECEIVED UNALLOWABLE MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES

ARMANDO CHIROPRACTIC SERVICES RECEIVED UNALLOWABLE MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES

ALLEGRA WILLOUGH CENTER 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."



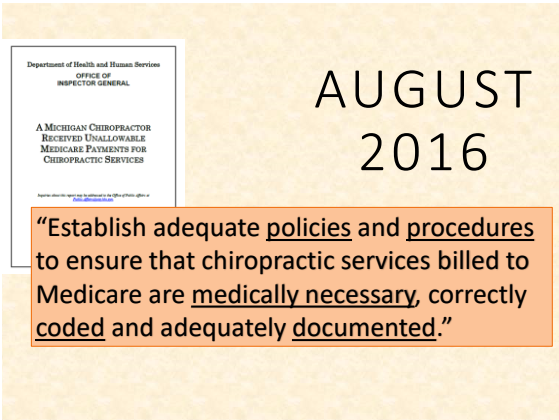
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Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

A MICHIGAN CHIROPRACTOR RECEIVED UNALLOWABLE MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES

AUGUST 2016

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



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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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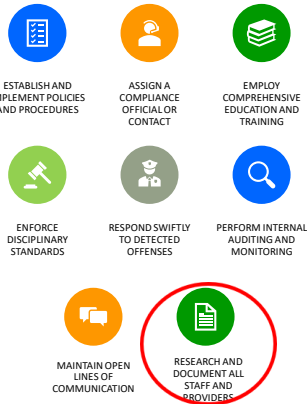




OIG Recommends Policies and Procedures to Address THESE Risks

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Elements of an OIG Compliance Program



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March 2015

OIG and HHS Announce over \$2.8 Billion in Returns from Joint Efforts to Combat Health Care Fraud
Administration recovers \$7.76 for every dollar spent to fight health care-related fraud and abuse, third highest on record.

More than \$2.8 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 \$7.76. 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 revvaluation of all existing 1.5 million Medicare suppliers and providers under new screening requirements. CMS will have requested all revvaluations 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 moratorium on the enrollment of new home health or ambulatory 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 quickly 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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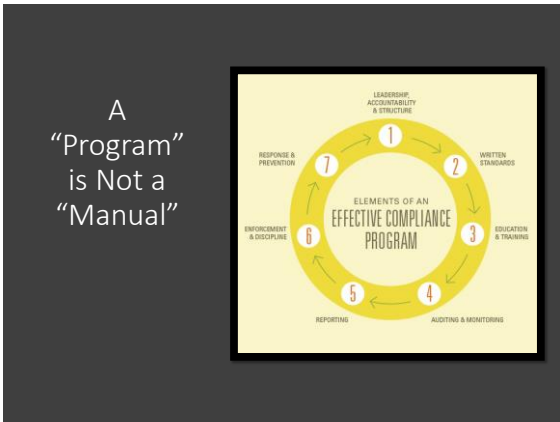
Can We Say Mitigating Factor Boys and Girls?

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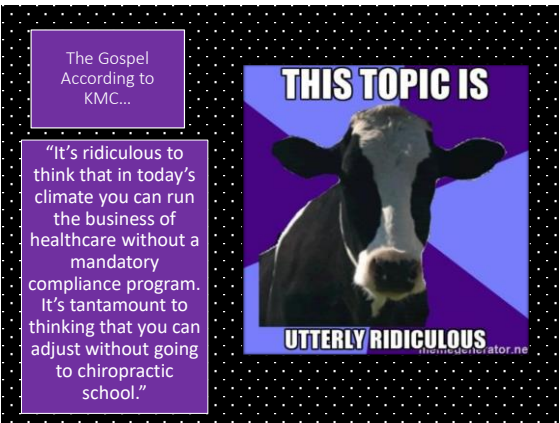
What An OIG Compliance Program Isn't

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A
“Program”
is Not a
“Manual”

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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.”

THIS TOPIC IS

UTTERLY RIDICULOUS

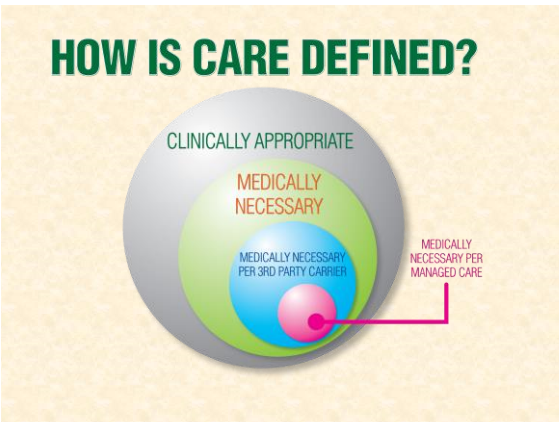
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KMC’s “Either/Or” Principle
Traditional Part B Medicare

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

Never S8990 with Traditional Part B Medicare

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HOW IS CARE DEFINED?

CLINICALLY APPROPRIATE

MEDICALLY NECESSARY

MEDICALLY NECESSARY PER 3RD PARTY CARRIER

MEDICALLY NECESSARY PER MANAGED CARE

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Is All Care Medically Necessary?

Clinically Appropriate Care	Medically Necessary Care
<ul style="list-style-type: none">• Maintenance care• Supportive care• Palliative care• Life enhancing and wellness care• Symptom relieving only• Care that doesn’t have as its goal improved function and correction• All care within your scope of practice, because Doctor is your first name	<ul style="list-style-type: none">• Acute problems• Care that can provide measurable functional improvement• Chronic care with expected functional improvement• Often defined by the carrier’s medical policy

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

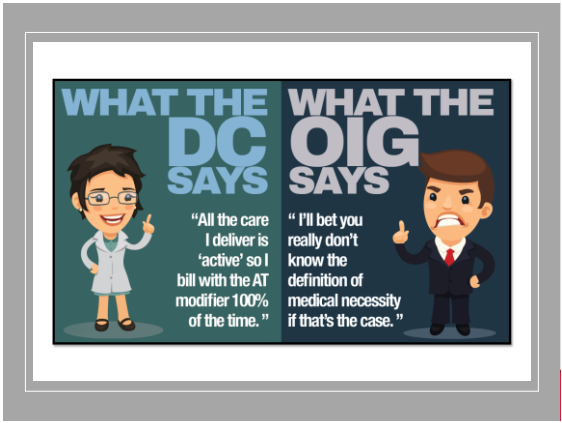
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Step One:
Must Know
The Difference

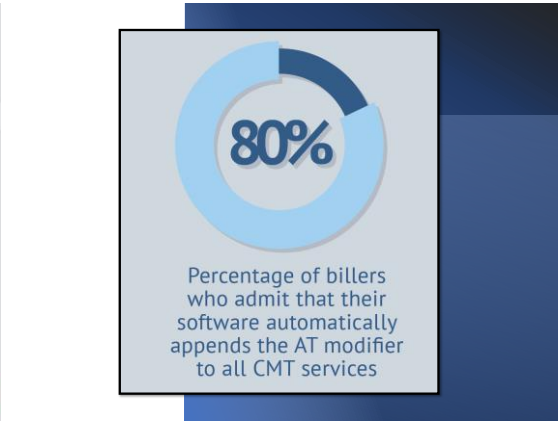
Chiropractic is Different
In Medicare

CHIROPRACTIC MEDICARE BENEFITS AND LIMITATIONS		Recognize the Fundamentals of Medicare Coverage for Chiropractic Services
Covered and Payable	Active Treatment (AT) Spinal Chiropractic Manipulative TX (CMT) CPT Codes 98940, 98941, 98942	
Covered but Not Payable	Spinal CMT codes are deemed Covered but Not Payable when performed for: <ul style="list-style-type: none">• Chiropractic maintenance treatment• More than one spinal manipulation per day *ABN form must be provided to the patient prior to rendering Covered but Not Payable services.	
Statutorily Excluded from Medicare Chiropractic Benefit	All services/supplies ordered or provided by a chiropractor, other than those defined above, are excluded from the Medicare benefit, and therefore the patient is responsible for payment. This includes but is not limited to: <ul style="list-style-type: none">• Extremity CMT 98943• X-rays• Products/supplies• Therapies• Exams• Alternative treatment protocols *ABN is not required for these services. Office Financial Policy is recommended to communicate these limitations of Medicare coverage.	

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Original Medicare vs Medicare Advantage

ORIGINAL MEDICARE	MEDICARE ADVANTAGE
1. Includes Part A and B	1. Includes Part A, Part B and usually Part D
2. Provides coverage for beneficiaries nationwide	2. An alternative to original Medicare whose carrier limits coverage to providers in a certain geographic area
3. Patient has a deductible and 20 % which applies to all covered services	3. Patient has a co-pay and sometimes deductible; often lower out of pocket costs than original Medicare
4. Benefits are directly from the Federal Government	4. Benefits are administered by a private plan such as Humana or Aetna
5. Requires you to use CMS' Mandatory ABN when rendering non-covered services	5. May require you to use their ABN when rendering non-covered or excluded service
6. Details on diagnoses, covered conditions and documentation are usually located in the Local Coverage Determinations(LCD) by the MAC	6. Coverage and benefits are located in the Payer's reimbursement policy or Medical Review Policy.
7. The appeals process is unique to original Medicare	7. MA appeals process is different than original Medicare
8. For DCs, spinal adjustment is the only covered service	8. Chiropractic coverage is dependent on the payer and may or may not be included in the plan.
9. Medicare does not pay for statutorily non-covered services (e.g., exams and therapies)	9. These plans may pay for otherwise statutorily non-covered services (e.g., exams and therapies)

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Step Two-Enrollment Part B

Things to do:

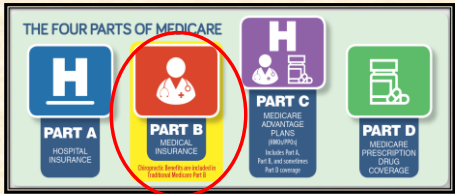
- ★ Apply for a National Provider Identification number (NPI)
- ★ Every provider must enroll in Medicare to treat a Medicare patient. **There is NO Opt-Out for chiropractors.**
- ★ Providers must enroll their corporate business entity in Medicare and attach individual provider numbers by reassigning benefits.

PART B

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Types of Medicare Coverage: Part B

- Basic Medicare Part B coverage is what most of the senior population have
- Medicare Part B is optional
- Medicare Part B is usually the primary coverage



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

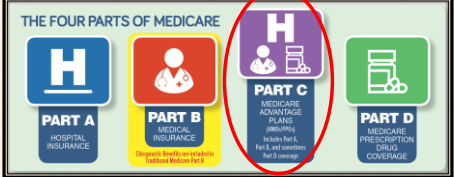
Accept and Treat Medicare Part B Patients



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Types of Medicare Coverage: Part C

- Also known as Medicare Advantage Plans or Replacement Plans— “Managed Care Medicare”
- Redirects benefits to a private carrier
- No Part A or B



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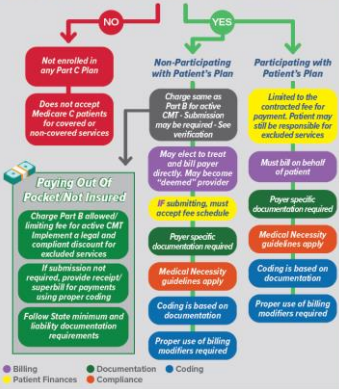
Step Three-Enroll in Part C Plans if Desired

★ 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.

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

Accepts and Treats 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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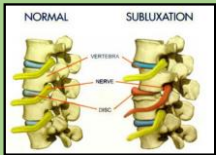


Percentage of chiropractic claims reviewed that did not document the medical necessity as required by Medicare, according to 2018 OIG audit reports

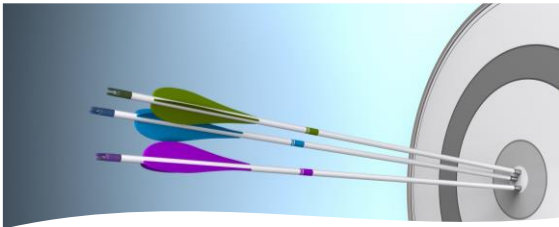
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The Opposite of Active Treatment

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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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

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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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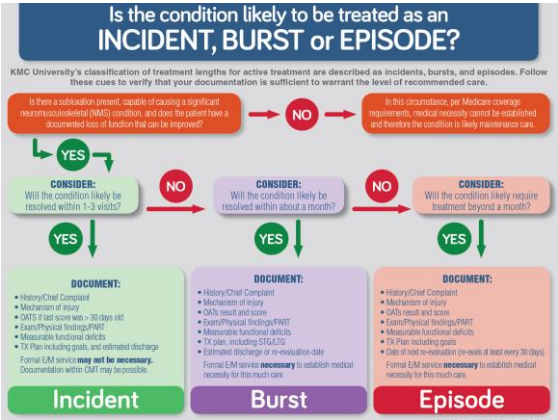


But You Have to Back it Up!

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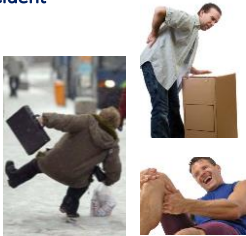
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Documenting Medical Necessity in History or Subjective if Incident

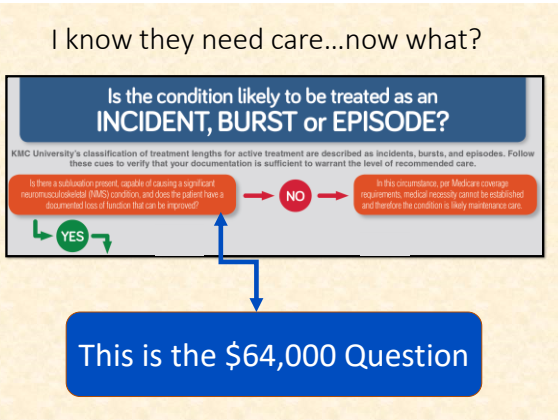
- Include a **Mechanism of Trauma** for every new patient or new episode
- Ask leading questions of your patient to elicit a specific incident that precipitated the pain and **Functional Loss** that the patient is experiencing
- "Before experiencing your low back pain, did you slip or fall?"
- "Can you 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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DCs Must Answer with Certainty!

Is there a subluxation present, capable of causing a significant neuromusculoskeletal (NMS) condition, and does the patient have a documented loss of function that can be improved?

If No....

In this circumstance, per Medicare coverage requirements, medical necessity cannot be established and therefore the condition is likely maintenance care.

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Incident Protocols

- Documentation within CMT
- May not be necessary to provide E/M
- All components of "initial" visit required
- Beware of incidents that happen once a month like clockwork

CONSIDER:
Will the condition likely be resolved within 1-3 visits?

YES ↓

DOCUMENT:

- History/Chief Complaint
- Mechanism of injury
- OATS if test score was > 30 days old
- Exam/Physical findings/PART
- Measurable functional deficits
- TX Plan including goals, and estimated discharge

Formal E/M service **may not be necessary**. Documentation within CMT may be possible.

Incident

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CONSIDER:
Will the condition likely be resolved within about a month?

YES ↓

DOCUMENT:

- History/Chief Complaint
- Mechanism of injury
- OATS result and score
- Exam/Physical findings/PART
- Measurable functional deficits
- TX plan, including STG/LTG
- Estimated discharge or re-evaluation date

Formal E/M service **necessary** to establish medical necessity for this much care.

Burst

Burst may be the most common used

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Typical Episode of Care

- Likely to require at least one re-evaluation
- Chronic diagnosis and significant lack of function
- Generally, more than a month of active treatment

NO → **CONSIDER:**
Will the condition likely require treatment beyond a month?

YES ↓

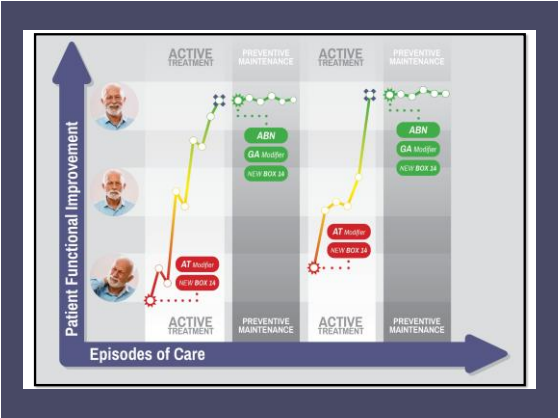
DOCUMENT:

- History/Chief Complaint
- Mechanism of injury
- OATS result and score
- Exam/Physical findings/PART
- Measurable functional deficits
- TX Plan including goals
- Date of next re-evaluation (re-evals at least every 30 days)

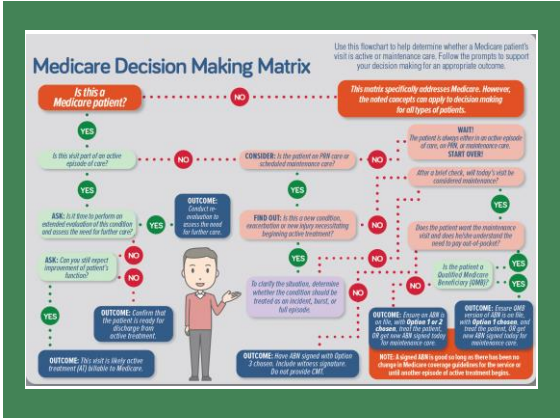
Formal E/M service **necessary** to establish medical necessity for this much care.

Episode

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Not Medicare Only...

Use this flowchart to help determine whether a Medicare patient's visit may be active or maintenance care. Follow the prompts to support your decision making for an appropriate outcome.

Is this a Medicare patient?

NO

The Mark addresses Medicare specifically. However, the concepts noted here can apply to decision making for all types of patients.

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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Let's Follow the Simple "YES" Path

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Let's Follow Alt. 1 "YES" Path

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Let's Follow Alt. 2 "YES" Path

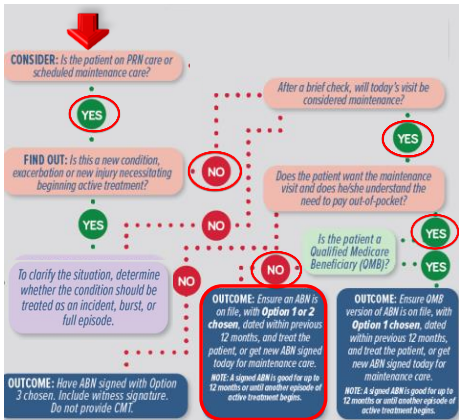
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The New Episode Path

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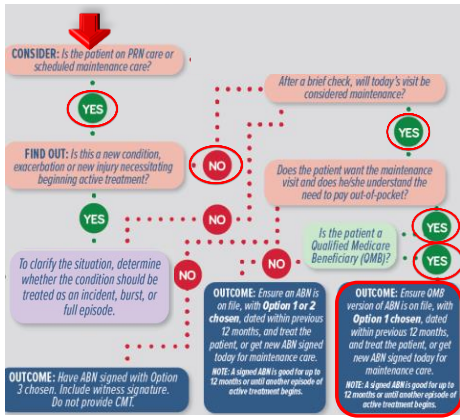
New Episode After Brief Check

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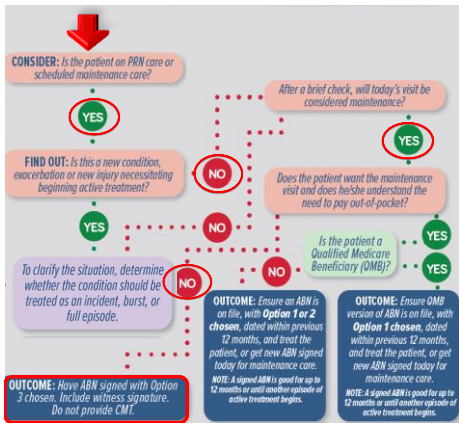
The True Non-AT Path Non-QMB

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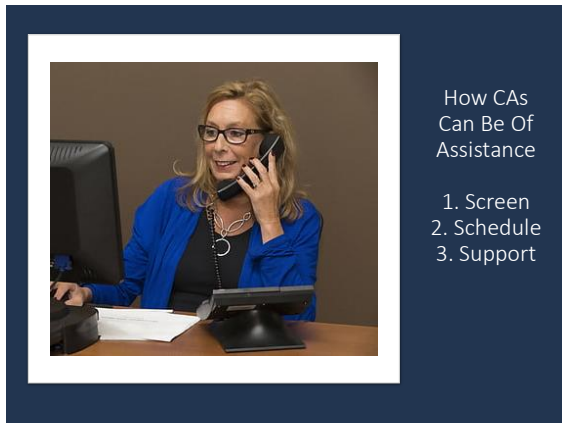
The True Non-AT Path For a QMB

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The Non-AT Path "No Thank You"

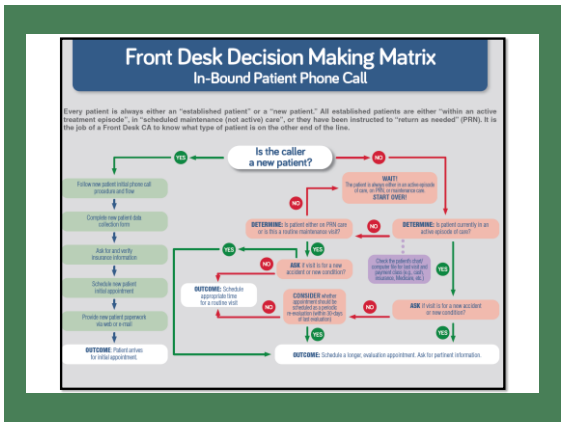
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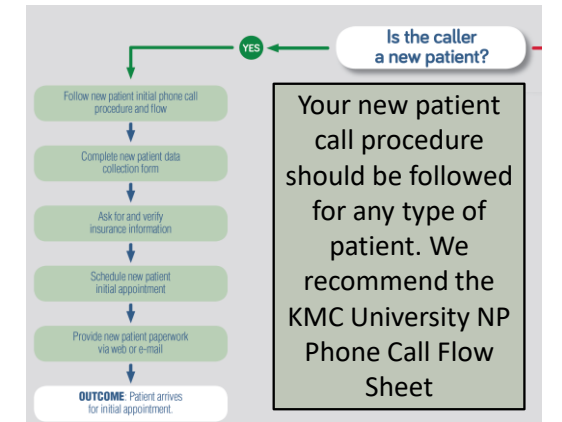
How CAs Can Be Of Assistance

- 1. Screen
- 2. Schedule
- 3. Support

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Your new patient call procedure should be followed for any type of patient. We recommend the KMC University NP Phone Call Flow Sheet

New Patient Data Collection Form

(This portion of the call will reassure the patients that they have called the right place.)

Name: Mary Jones

Who may we thank for referring you? Husband Mark Jones

What type of problem are you having? Severe neck pain after sleeping awkwardly

How long has this been going on? About a week Result of accident? ☒ Yes ☐ No

What have you done for this?
☒ OTC Meds Tylenol ☐ Massage ☐ Saw DC
☐ Saw MD ☐ Other

(Tell them your doctor has seen this problem before and has had great results. Express compassion and concern when speaking to new patients.)

Appointment Date/Time: Wednesday October 27 9am

Now I'm going to ask you some questions that will save you time when you are in the office...

Address: 124 Main Street DOB: 12/23/41
City: Orange State: CA ZIP: 98989 Phone: 914-236-5897 ☒ Cell ☐ Home
Email Address: MaryS@yahoo.com

Do you have some kind of insurance that you'd like us to assist in filing for you? ☐ Yes ☒ No

Would you please get your insurance/Medicare Card/accident information so we can review it?

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Do you have some kind of insurance that you'd like us to assist in filing for you? ☒ Yes ☐ No

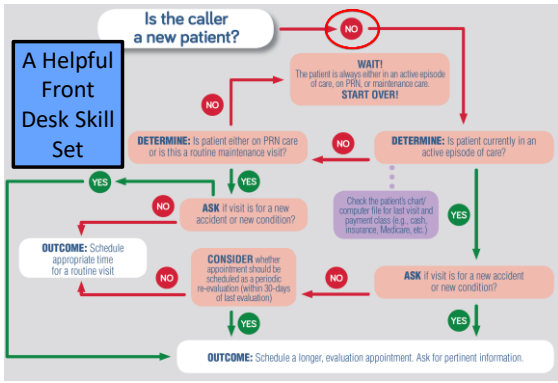
Would you please get your insurance/Medicare Card/accident information so we can review it?

MAJOR MEDICAL INSURANCE	MEDICARE	ACCIDENT / INJURY	WORKERS COMPENSATION
United Health Care Insurance Company 800-965-4587 Phone Self Insured 12/23/41 Insured DOB AP5864KL ID# 159753 Policy# Group# Employer	Traditional Medicare MBI: K978G42FM01 Follow Through If Add'l Coverage <input checked="" type="radio"/> True Secondary, or Supplemental/ Medigap <input type="radio"/> If Add'l Coverage is selected, gather info at call. OR Medicare Replacement Plan Name of plan: Office participants: <input type="radio"/> YES <input checked="" type="radio"/> NO If office doesn't participate, meet office as cash. If office participates, gather info at call.	Reported? <input type="radio"/> YES <input checked="" type="radio"/> NO Insurance Company Supervisor Claim# Adjuster Phone# Supervisor or HR DOI Claim#	Reported? <input type="radio"/> YES <input checked="" type="radio"/> NO Supervisor Phone# Supervisor or HR DOI Claim#

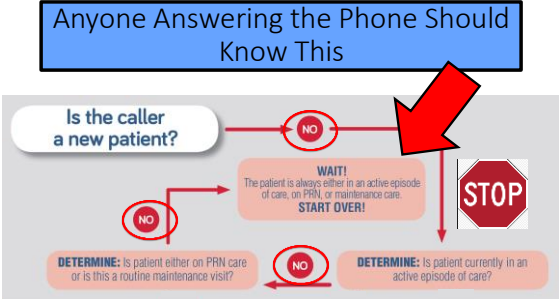
Date: _____ Time: _____
Staff Member: _____

☒ Confirm Office Location ☐ NP Paperwork ☐ Website ☐ Email ☐ Discussed Fees/CHUS ☒ YES ☐ NO

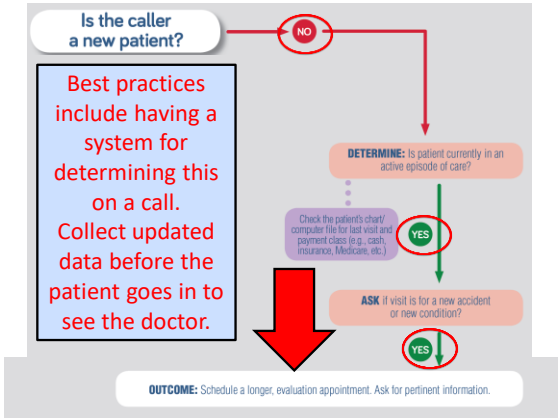
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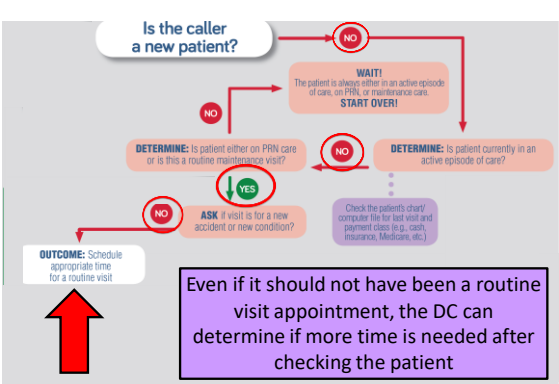
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Keys to Successful Active Care

- ✓ More than just appending the modifier AT to CMT services
- ✓ Make sure Box 14 on the 1500 billing form corresponds to the beginning of the current episode of care
- ✓ Don't have an ABN form signed during active treatment. It's mandatory when a covered service may not be medically necessary.
- ✓ Implement the required documentation standards for medical necessity
- ✓ Initiate re-evals on a regular basis and report outcomes promptly
- ✓ Self-audit documentation on a regular basis as part of your mandatory compliance program
- ✓ Educate your patients on active care vs maintenance care prior to initiating treatment

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A Coding Primer



Procedure codes are represented by CPT and HCPCS

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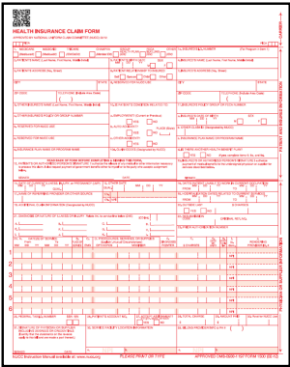
You Can't Make That Up!

- Coding must match your service
- Not everything has a code
- Standard coding guidelines apply
- Certain codes can't be combined with one another
- Just because there is a code, it doesn't mean it's covered by the payer
- When in doubt, ask!



81

Coding Tells the Patient's Story to Payers



82

Basic Rules of Coding

Select the code that most closely defines the service(s) rendered

Documentation from the patient encounter determines the codes used

Before using a code, be sure all required elements to satisfy the code description have been met

Do not guess or assume codes

Codes must be confirmed and supported by documentation

83



Accurate & Complete Coding

- Consistency – no matter who is paying for the service
- Objective– high-quality health data to payers
- Accurate– one that best describes the service(s)



84

Evaluation and Management (E/M) Coding

- New Patient Office Visit
- 99202-99205
 - Used on never-before-seen patients and those away at least 3 years
- Established Patient Office Visit
- 99211-99215
 - Used on anyone seen within 3 years



85

Proper Use of 99211



- The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional.
- For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.



86

Option 1-Code According to Time

Table 1: 2021 Requirements for E/M Codes 99202-99205			
Code	History/Exam	MDM	Total Minutes
99202		Straightforward	15-29
99203	Medically appropriate history and/or examination	Low	30-44
99204		Moderate	45-59
99205		High	60-74

Table 2: 2021 Requirements for E/M Codes 99212-99215			
Code	History/Exam	MDM	Total Minutes
99212		Straightforward	10-19
99213	Medically appropriate history and/or examination	Low	20-29
99214		Moderate	30-39
99215		High	40-54



87

Option 2- Code by Medical Decision Making

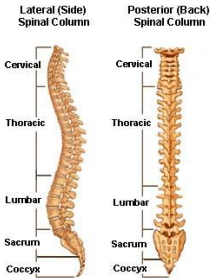
Elements of Medical Decision Making			
Code	Level of MDM Based on 2 out of 3 Elements of MDM	Number and Complexity of Problems Addressed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99212	Straightforward	N/A	N/A
99213		Minimal • 1 self-limited or minor problem	Minimal risk of morbidity from additional diagnostic testing or treatment
99214	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Low risk of morbidity from additional diagnostic testing or treatment
99215		Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique source(s); • Review of the result(s) of each unique test(s); • Ordering of each unique test(s) or Category 2: Assessment requiring an independent history/physical (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk from manipulation and home exercise stretches



88

Spine and Extremities

- 98940 – 1-2 Regions
 - 98941 – 3-4 Regions
 - 98942 – 5 Regions
 - 98943 - Extremities
- Choose the most comprehensive physician code to describe chiropractic services rendered.



89

Passive vs. Active Therapies and Modalities

- **Passive treatments** require the patient to be a submissive recipient of treatment
- **Passive treatment** can help with immediate pain relief, but **active treatment** keeps the patient functional in the long term
- **Passive modalities** are common in the earlier phases of a treatment plan
- **Active treatment** is most often recognized as exercise, stretching, and strengthening procedures



90

Therapies Can be Supervised or Constant Attendance

Supervised Modalities:

- Billable once per patient encounter
- Able to be delegated to team members, with provider in the office, dependent on state and payer guidelines
- All passive modalities where the patient is not actively involved
- Not required to be constantly attended by the provider of service, but within the office

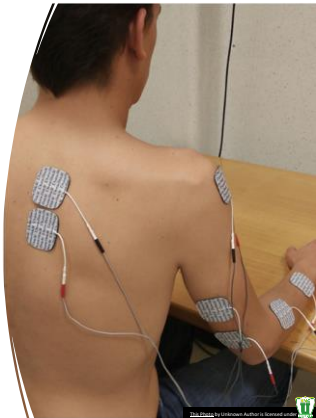
Constant Attendance Modalities:

- Time-Based for billing
- One-on-one direct attendance is required
- State and payer regulations determine who must be in attendance
- Generally, higher-level passive services requiring constant attendance

91

Examples of Supervised Modalities

- Heat and Cold Therapies
 - Hot Packs
 - Ice Packs
 - Analgesics
- Electrical Therapies
 - Electrical Stimulation-unattended
 - TENS Units
- Mechanical Traction
 - Static traction
 - Decompression



92



Examples of Constant Attendance Modalities

- Ultrasound-attended
- Electrical Muscle Stimulation-attended
- Laser Therapy



93

Active Care Can Also be Passive and Active

- Active care rehabilitation is considered a therapeutic procedure
- Therapeutic procedures require constant attendance-state and payers determine level of supervision or attendance required
- Time-Based for billing
- Passive exercises and treatments are used to prevent stiffness and regain range of motion in muscles
- Active exercises help strengthen the communication between the brain and body for increased movement
- Most active care treatment plans have goals related to improved function and increased ability to perform daily activities



94

Exercise Services: Documentation and Intent



95



96

Therapeutic Procedures (97110-97546)

- Therapeutic Procedures are time-based codes for billing purposes
- The patient is ACTIVE in the encounter
- Requires direct one-on-one patient contact
- Documentation should include both the total time spent and the time spent doing each activity/exercise.
- Codes are billed per 15 min increments

97

97110
Therapeutic Exercise

- Therapeutic Exercise, 15 mins. Each--One or more areas
- Incorporates **one**:
 - Strength
 - Endurance
 - Range of motion
 - Flexibility
- Must show functional deficit in the above during examination

215
473 Coding

98

Therapeutic Exercises-97110

- Instructing and directly supervising the exercises
- Purpose is to develop and/or maintain muscle strength and flexibility including range of motion, stretching and postural drainage
- Performed actively, active-assisted, or passively (e.g., treadmill, isokinetic exercise lumbar stabilization, stretching, strengthening)

99

- Ther-EX considered medically necessary for loss or restriction of joint motion, strength, functional capacity or mobility that resulted from disease or injury.
- Standard treatment is 12 to 18 visits within a 4- to 6-week period
- Exercising done subsequently without a physician or therapist present for supervision = not covered

100

What About Post-Isometric Relaxation? (PIR)



- Often mistakenly billed as 97140
- Constant attendance
- Is clearly an exercise due to stretching

101

Question Asked of AMA-CPT:

Would "PIR" or Post Isometric Relaxation technique be properly coded as CPT 97110 – Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility? Post Isometric Relaxation is a therapeutic procedure whereby the provider places the muscle in a stretched position. Then an isometric contraction is exerted against minimal resistance. Relaxation and then gentle stretch follow as the muscle releases. The primary goal is to increase a patient's range of motion and flexibility.

An example of cervical paraspinal PIR is as follows: Cervical paraspinal PIR is performed with the patient supine, while the doctor slowly lifts the patient's head toward the ceiling. Once a comfortable stretch is felt, the patient is asked to push their head back (with approximately 10% of their strength), while the doctor resists this movement; thus, creating an isometric contraction in the paraspinal muscles. This position is held for 8–10 seconds. The patient is then asked to inhale deeply and, upon exhalation, is instructed to relax while the doctor lifts the patient's head a little further towards the ceiling. After an 8–10 second stretch, the protocol is repeated (to patient and tissue tolerance) for 3 to 4 more repetitions.

102

Answer
Provided

The CPT Knowledge Base responded as follows:

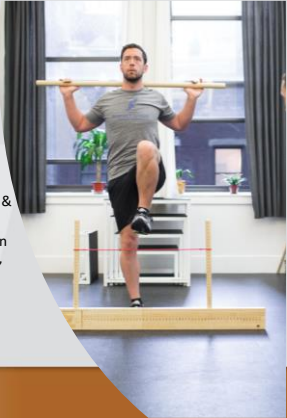
Your inquiry was forwarded to our reviewer for review and comment. After further review, your inquiry was submitted to the American Physical Therapy Association and the American Occupational Therapy Association, and the following response was obtained:

"Yes, 97110 would be the most appropriate code to describe this therapeutic exercise technique as described."

103

97112 Neuromuscular Re-education (NMRE)

- Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, & proprioception
- Proprioceptive Neuromuscular Facilitation (PNF), Feldenkrais, Bobath, BAP'S Boards, and desensitization techniques
- Most likely indicated for neurological conditions




215
473

Coding

104

Neuromuscular Re-education-97112


- This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception to a person that has had muscle paralysis and is now recovering or regenerating.
- Goal is to develop conscious control of individual muscles and awareness of extremities position



105

Neuromuscular Re-Education-97112

- May be considered necessary for impairment necessary for impairment affect the body's neuromuscular system (e.g., poor sitting/standing balance, gross and fine motor, hypo/hypertonicity, from disease or injury, severe trauma to the system, cerebral vascular and systemic neurological
- Standard treatment is 12 to 16 visits within a 4- to 6-week period.



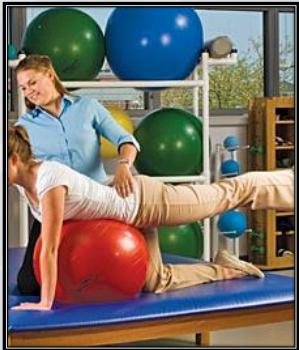
215
473

Coding

106

97530 Therapeutic Activities

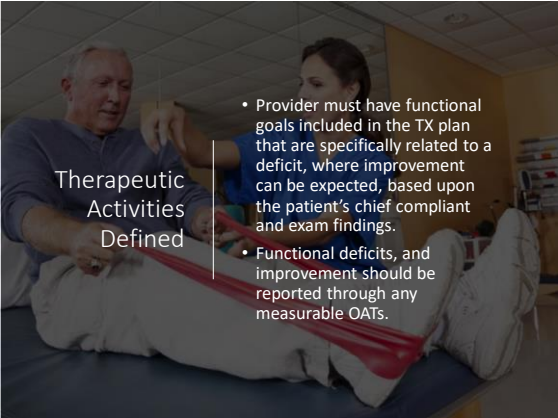
- Dynamic activities to improve functional performance, direct (one-on-one) with the patient (15 minutes)
- Incorporates **two** or more:
 - Strength
 - Endurance
 - Range of motion
 - Flexibility
- Must show functional deficit in the above during examination



107

Therapeutic Activities Defined

- Provider must have functional goals included in the TX plan that are specifically related to a deficit, where improvement can be expected, based upon the patient's chief complaint and exam findings.
- Functional deficits, and improvement should be reported through any measurable OATs.



108



Therapeutic Activities-97530

- This procedure involves using functional activities (e.g., bending, lifting, carrying, reaching, pushing, pulling, stooping, catching and overhead activities) to improve functional performance in a progressive manner
- The activities are usually directed at a loss or restriction of mobility, strength, balance or coordination
- Require the professional skills of a provider
- Are designed to address a specific functional need

109

Therapeutic Activities-97530

- May be appropriate after a patient has completed exercises focused on strengthening and range of motion, but needs to be progressed to more function-based activities
- Dynamic activities must be part of an active treatment plan and directed at a specific outcome

110



97530 Therapeutic Activities

- Dynamic activities to improve functional performance, directly (one-on-one) with the patient (15 minutes)
- **Specific activity of daily/work living is intended to a specific improvement**
- Gauge progress with periodic re-evaluations and updated Outcomes Assessment Tool

111

AMA/CPT Says “Each 15 Minutes”

CPT® Code Set

Medicine, Services and Procedures

Click to view/whole add'l coding info...

Physical Medicine and Rehabilitation Evaluations

Click to view/whole add'l coding info...

Physical Medicine and Rehabilitation Therapeutic Procedures

Click to view/whole add'l coding info...

Therapeutic procedure, 1 or more areas, each 15 minutes

Code(s)	Description	Icons
97110	THERAPEUTIC PX 1+ AREAS EACH 15 MIN EXERCISES	
97112	THER PX 1+ AREAS EACH 15 MIN NEUROLOGIC REEDUCA	
97113	THER PX 1+ AREAS EACH 15 MIN AQUA THER W/WEIGHS	
97116	THER PX 1+ AREAS EA 15 MIN GAIT TRAIN/ W/STAIR	
97124	THER PX 1+ AREAS EACH 15 MINUTES MASSAGE	

112

Timed Treatment Codes

For a single timed code being billed in a visit:

- Less than 8 min = 0
- 8 up to 23 min = 1
- 23 up to 38 min = 2
- 38 up to 53 min = 3
- 53 up to 68 min = 4
- And so on

For multiple timed codes provided in the same session, add up the total minutes of skilled, one-on-one, time-based therapy and divide that total by 15

- If eight or more minutes are left over, you can bill for one more unit
- If seven or fewer minutes remain, you cannot bill an additional unit

113

Coding Modifiers

Two-digit or two-character codes that are often appended to CPT or HCPCS codes

Provide more information/detail for the service/item being provided

Required by payors for proper processing and payment of covered items/services

114

Modifiers

These modifiers communicate additional information about a service performed or a product dispensed. Modifiers go to box 202 of the CMS-1500 claim form. Modifiers are used to indicate billing for the same service performed on the same day or to indicate that a service is being performed on a different day than the date of service. Modifiers are also used to indicate that a service is being performed on a different day than the date of service.

Modifier	Description
25	Significant, separately identifiable E/M service by or for the same physician or other qualified health care professional on the same day of the procedure or other service.
59	Distinct procedural service. This modifier is used to indicate that a procedure or service is being performed on the same day as another procedure or service, but is not an integral part of the same procedure or service.
66	Staged procedure. This modifier is used to indicate that a procedure or service is being performed on the same day as another procedure or service, but is not an integral part of the same procedure or service.
76	Repeat procedure by the same physician or other qualified health care professional on the same day of the procedure or other service.
77	Repeat procedure by another physician or other qualified health care professional on the same day of the procedure or other service.
86	Staged procedure by another physician or other qualified health care professional on the same day of the procedure or other service.
87	Staged procedure by another physician or other qualified health care professional on the same day of the procedure or other service.
91	Repeat procedure by the same physician or other qualified health care professional on a different day of the procedure or other service.
92	Repeat procedure by another physician or other qualified health care professional on a different day of the procedure or other service.
93	Staged procedure by the same physician or other qualified health care professional on a different day of the procedure or other service.
94	Staged procedure by another physician or other qualified health care professional on a different day of the procedure or other service.
95	Staged procedure by the same physician or other qualified health care professional on a different day of the procedure or other service.
96	Staged procedure by another physician or other qualified health care professional on a different day of the procedure or other service.
97	Staged procedure by the same physician or other qualified health care professional on a different day of the procedure or other service.
98	Staged procedure by another physician or other qualified health care professional on a different day of the procedure or other service.
99	Staged procedure by the same physician or other qualified health care professional on a different day of the procedure or other service.

115



Orthotics and Their Clinical Application

116

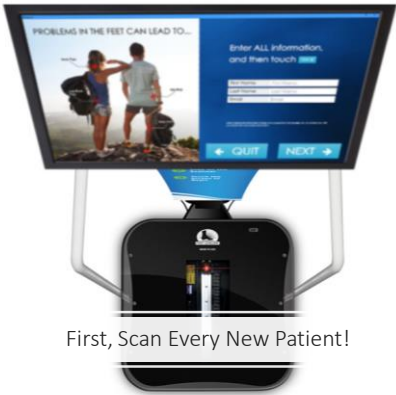
You Know
You Need to
Prescribe
Them...Now
What?





- Prescribe what's appropriate for the patient
- Know that there are options for self-payment of orthotics just like for other healthcare
- Don't confuse prescribing with getting paid

117

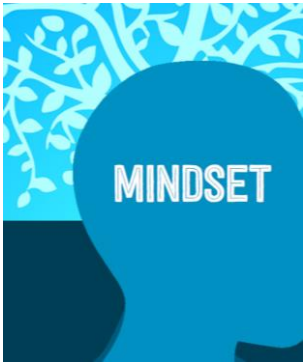


First, Scan Every New Patient!

118

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



119

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



120

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



121

Patient
History
Supports
Orthotics
Prescription



Ask about past orthotics usage

Ask about the types of
treatments required in the
medical review policy:

"Have you ever used over the
counter inserts and what was
the outcome?"

"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?"

122

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 function in everyday life. Please answer every section and mark in each section only ONE box which applies to you. The marks you put indicate that out 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 take painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give considerable relief from pain.
☐ Painkillers give only slight relief from the pain.
☐ Painkillers do not help at all.

Section 2 - Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but I do cause extra pain.
☐ I am unable 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 I stay in bed.

Section 3 - Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but I give extra pain.
☐ I can lift moderate weights but I give extra pain.
☐ I can lift only light weights.
☐ I cannot lift or carry anything at all.

Section 4 - Walking

☐ I can walk without any extra pain.
☐ I can walk without extra pain but I give extra pain.
☐ I can walk with some extra pain but I give extra pain.
☐ I can walk with a lot of extra pain.
☐ I cannot walk at all.

Section 5 - Standing

☐ I can stand as long as I want but I give extra pain.
☐ I can stand as long as I want but I give extra pain.
☐ I can stand as long as I want but I give extra pain.
☐ I can stand as long as I want but I give extra pain.
☐ I can stand as long as I want but I give extra pain.

Section 6 - 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 6 hours sleep.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 7 - Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but I give extra pain.
☐ My social life is normal but I give extra pain.
☐ My social life is normal but I give extra pain.
☐ My social life is normal but I give extra pain.

Section 8 - Travelling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but I give extra pain.
☐ I can travel anywhere but I give extra pain.
☐ I can travel anywhere but I give extra pain.
☐ I can travel anywhere but I give extra pain.

123

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

124



5
Red
Flags

125

Sample Foot Exam

FUNCTIONAL FOOT EXAMINATION

Patient's Name _____ Doctor's Name _____ Date of Examination: _____

FOOT EXAMINATIONS PERFORMED

☐ Inspection ☐ Palpation ☐ Alignment Weight Bearing ☐ Range of Motion ☐ Neurology ☐ Gait Analysis

☐ Digital Foot Evaluation ☐ Bilateral Foot Cast

REMARKS:

OBJECTIVE FINDINGS

INSPECTION: PRESENT OR ABSENT (RIGHT OR LEFT)

☐ Heaviness (Blue Hair) (PAU) (RL) ☐ Limp (PAU) (RL) ☐ Bruise (Bru, Tap, Spine, Cast, Band) (PAU) (RL) ☐ Ankle/Forefoot (Circumfer, Calc, Widen) (PAU) (RL)

☐ Plantar Warts (PAU) (RL) ☐ Corns (Circumfer, Rubbery) (PAU) (RL) ☐ Eczyema (PAU) (RL) ☐ Toenails ☐ Extensive Callus Formation (PAU) (RL)

PALPATION: <= (RIGHT OR LEFT)

☐ Peroneal Tendon (PAU) (RL) ☐ Tibial Tendon (PAU) (RL) ☐ Plantar Fascia (PAU) (RL) ☐ Metatarsal Tendon (PAU) (RL) ☐ Calcaneal Tendon (PAU) (RL) ☐ Achilles Tendon (PAU) (RL)

ALIGNMENT WEIGHT BEARING: PRESENT OR ABSENT (RIGHT OR LEFT)

☐ Pronation (PAU) (RL) ☐ Supination (PAU) (RL) ☐ Pes Planus (PAU) (RL) ☐ Pes Cavus (PAU) (RL) ☐ Flatfoot (PAU) (RL)

☐ Forefoot Valgus (PAU) (RL) ☐ Forefoot Varus (PAU) (RL) ☐ Calcaneal Valgus (PAU) (RL) ☐ Calcaneal Varus (PAU) (RL) ☐ Genu Valgus (PAU) (RL)

126

127



128

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Dispense and
Train
Orthotics

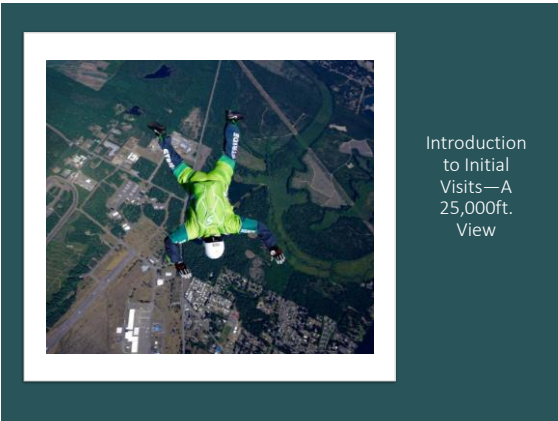
- Once ordered and received, spend time the day dispensed
- Discuss wearing schedule
- Insert in shoes
- Review gait
- Confirm that the fit is good
- Recheck during wearing schedule



133



134



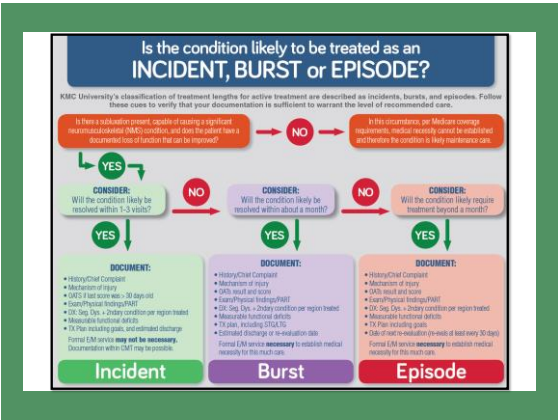
135



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

136



137



138



139

Medicare Documentation Guidelines in the Absence of Others

Initial Visit	Subsequent Visits
<ul style="list-style-type: none">• History• Description of Present Illness• Physical Exam• Diagnosis• Treatment Plan• Date of initial treatment	<ul style="list-style-type: none">• History• Review of chief complaint• Physical Exam• Documentation of daily treatment• Progress related to treatment goals/plan

140

What About an Incident?

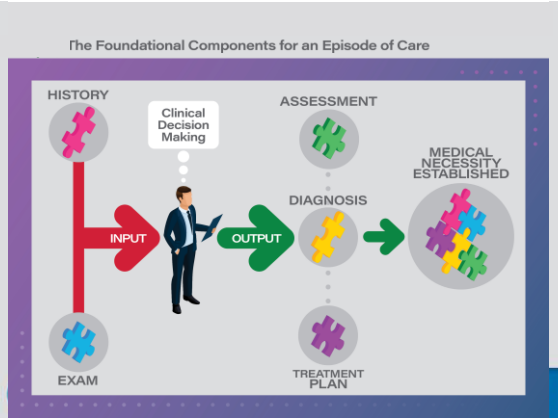
- A brief episode of care may not require full E/M
- Simple flare-ups necessitating 2-3 visits can be documented differently
- Components of initial visit are still required to establish the episode
- Examples are provided in the modular training

141

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

142



143

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

144

Initial Visit	
Initial and follow-up visits are more robust than daily routine office visits or SOAP notes. An Evaluation and Management (E/M) service is documented at an initial visit and/or the groundwork for the entire course of treatment. An initial visit is any visit that sets 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: <ul style="list-style-type: none">• Symptoms that caused the patient to seek treatment and when the problem started• Description of the nature of the current injury• Quality, character, frequency, and location of the symptoms• History of relevant family history and past health history	<ul style="list-style-type: none">• Each initial visit, whether a new patient or new episode of active care, must include necessary history components of the E/M service, termed as the "narrative"• Identification of specific functional activities that are affected by the condition, including measurable deficits in Activities of Daily Living (ADLs)• With multiple complaints, outline each complaint with details as noted• The visit and documentation clearly forms the baseline, foundational visit for the episode of care, detailing why the patient is seeking care• There is a clear mechanism of injury or concern regarding when the condition started. It is unclear when the accident, fall, or incident, etc., took place and include when the pain started• Update any changes in family and health history, and social history or habits on returning patients, as appropriate
An evaluation of the musculoskeletal system (a review system determined through a physical exam)	<ul style="list-style-type: none">• The components of PMPT should be present for all spinal regions in which there is a complaint. Finding a way to identify the sublocation, include the findings and date of the study• Appropriate orthopedic and neurological test performed to identify the components and justify the diagnosis• Specific symptoms for primary areas to be treated are clearly isolated• Secondary components, or symptomatic findings are clearly indicated• Include additional body systems or areas that may be affecting, or be affected by, the presenting problem
A diagnosis. <i>Note:</i> The primary diagnosis for Medicare must be substantiated that includes a dated note or that is identified by a more descriptive of sublocation.	<ul style="list-style-type: none">• The medical record contains written diagnoses for each condition/region to be addressed, with or without CD-10 codes• Diagnoses are "linked" per the Medicare rules, with primary as sublocation (joint/muscle/ligament) 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 required activities of daily living and other measures to evaluate the effectiveness of the treatment.	<ul style="list-style-type: none">• Include the expected duration or days/week/visit for this active episode of care• Indicate the frequency of visits up to the first re-evaluation or discharge if the episode is expected but less than a month• List short-term and long-term goals related to the functional deficits indicated in the history section of the note. Ensure they can be easily measured on a visit-to-visit basis• Indicate what effectiveness measure you plan to use to determine whether the treatment is working. Often, Outcome Assessment Tools (OATs) are used, and the initial score is recorded with a problem. This is usually measured at re-evaluation intervals

145



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

146



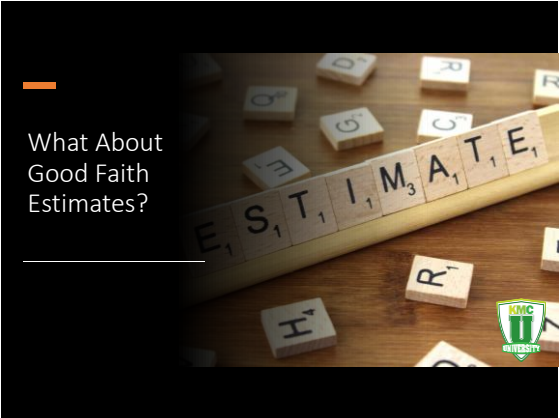
Let's Talk No Surprises Act

147

The No Surprises Act Complexity

- Independent Dispute Resolution (IDR) Process
- Requires Good Faith Estimates**
- Advance Explanation of Benefits
- Patient Provider Dispute Resolution
- Transparency & Balance Billing Protections

148




What About Good Faith Estimates?

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"Health care providers and health care facilities are required under PHS Act section 2799B-6 to furnish a **notification of the good faith estimate of expected charges to an uninsured (or self-pay) individual** who schedules an item or service..."

Good Faith Estimate



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Providers are defined as..

" physicians or other health care providers acting within the scope of their state licenses"

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Self-Pay Patients

Uninsured

Does not plan to use their insurance benefits to pay for the services provided by the physician—OON!

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Who Also Gets One?

"...to an individual who has not yet scheduled an item or service, but requests a good faith estimate"

Good Faith Estimate

John Doe Chiropractic & Wellness Center
Dr. John Doe
TIN: 00-0000000

Patient Information

John, Judy Jones
Address: 1 Paradise Lane
City: Paradise, State: KY, Zip: 40000
Date of Birth: 04-02-1997
Age: 34

Estimate

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Exam (Evaluation)	low back, shoulder, neck, midback		1	145.00	145.00
Imaging	diagnostic		1-2	105.00	210.00
Electrical Stimulation	muscle spasm		1	36.00	36.00

Total Expected Charges \$ 521.00

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Exam (Evaluation)	low back, shoulder, neck, midback		1	145.00	145.00
Imaging	diagnostic		1-2	105.00	210.00
Electrical Stimulation	muscle spasm		1	36.00	36.00

Total Expected Charges \$ 521.00

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New Patient Visit Customization with a Range

Estimate

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Exam (Evaluation)	Pain		1	145-230.00	230.00
Imaging	diagnostic		1-2	65-105	215.00
Electrical Stimulation	muscle spasm		1	36.00	36.00

Total Expected Charges \$ 481.00

Second Step of the GFE Process

Financial Report of Findings
Good Faith Estimate

John Doe Chiropractic & Wellness Center
Dr. John Doe
TIN: 00-0000000

Patient Information

John, Judy Jones
Address: 1 Paradise Lane
City: Simplicity, State: KY, Zip: 41000
Date of Birth: 04-02-1997
Age: 34
Phone: 555-555-1111
Email: contactme@gmail.com

The following is a list of items and services which the provider(s) anticipate you will need over your initial exam or re-exam has been completed. The recommended treatment is in light of (S, O, R, C, D, L, and is reported in compliance (S, O, R, C, D, L, 2005).

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas		M9900, M9902, S3300A4	12	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12	45.00	540.00
Exercise Therapy	Shoulder dysfunction, lower extremities	M9900, M9903	20	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

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Treatment Plan from the DC					
The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed. The recommended treatment is to begin on 06/20/2022 , and is projected to completed by 08/01/2022 .					
SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas	Neck/Thoracic/Lumbar Pain	M9900.M9902.S335.xx4	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	2 (LIMITED VALUE)	45.00	540.00
Exercise Therapy	General Postural/Control Dysfunction	M9900.M9903	20 (LIMITED VALUE)	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

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Maintenance Plan					
The following is a list of items and services which the provider/clinic anticipates you will need once your initial exam or re-exam has been completed. The recommended treatment is to begin on <u>06/20/2022</u> , and is projected to completed by <u>08/01/2022</u> .					
SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Adjustment S8990	Maintenance		24		

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