1

Know the Messenger

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

2

Our Plan for Today

Recognize	Better recognize the differences 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 to intake requirements and establish a baseline for episodes of care
Conduct	Conduct required elements of a compliant HIPAA program as it relates to the business of healthcare

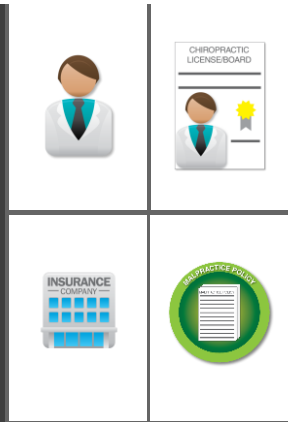
3

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

6

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?

7

8

Your Patient's Flow Under Care

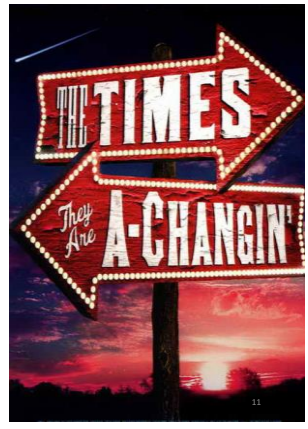
9

This Now Becomes the Story You May Have to Tell

10

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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the $ business of health care

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

13

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.

14

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

15

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.

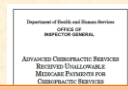
We also recognize that compliance programs are not uniform in size and scope and that compliance activities in a smaller setting, such as a solo practitioner's office, may look very different than those in larger setting, such as a multi-specialty group.

16

Outliers Audited & Made Example

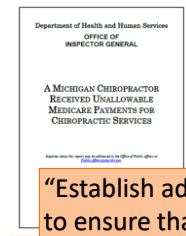
2013 | 2014 | 2015 | 2015






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

17



AUGUST 2016

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

18

What An OIG Compliance Program IS

19

Compliance Program Purpose

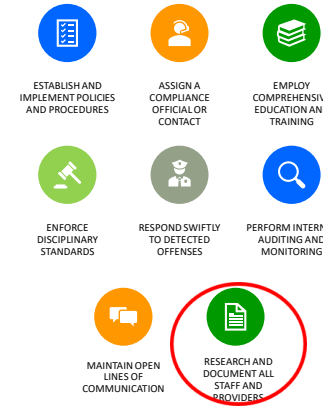
Integrate policies and procedures into the physician's practice that are necessary to promote adherence to federal and state laws and statutes and regulations applicable to the delivery of healthcare services

20

OIG Recommends Policies and Procedures to Address THESE Risks

21

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.

23

Can We Say Mitigating Factor Boys and Girls?

24

25

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."

27

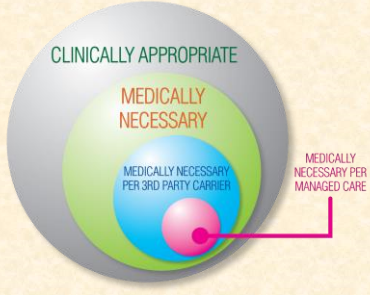
KMC's "Either/Or" Principle Traditional Part B Medicare

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

28

HOW IS CARE DEFINED?



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Is All Care Medically Necessary?

Clinically Appropriate Care

- 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

Medically Necessary Care

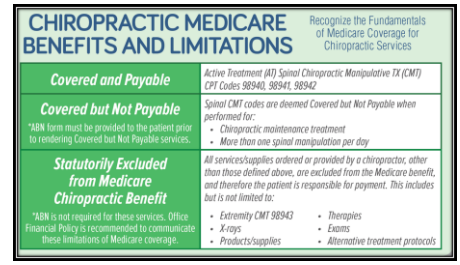
- Acute problems
- Care that can provide measurable functional improvement
- Chronic care with expected functional improvement
- Often defined by the carrier's medical policy

30

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

31

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



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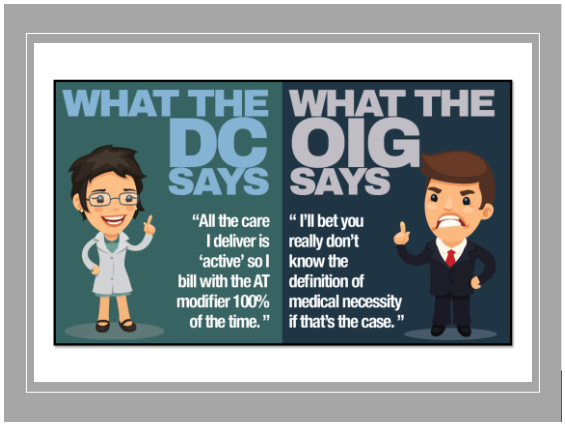

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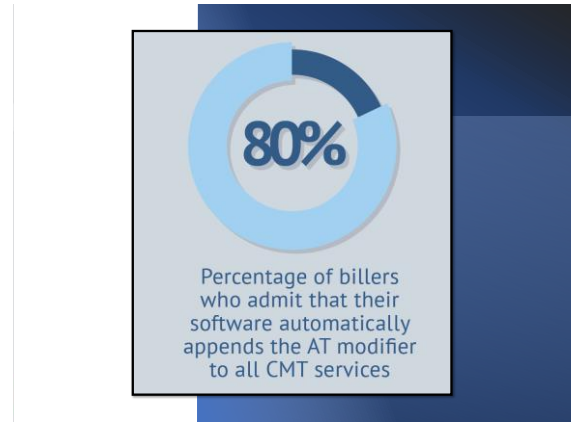

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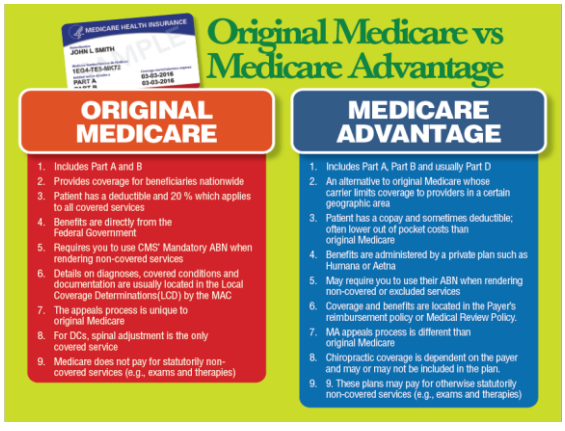

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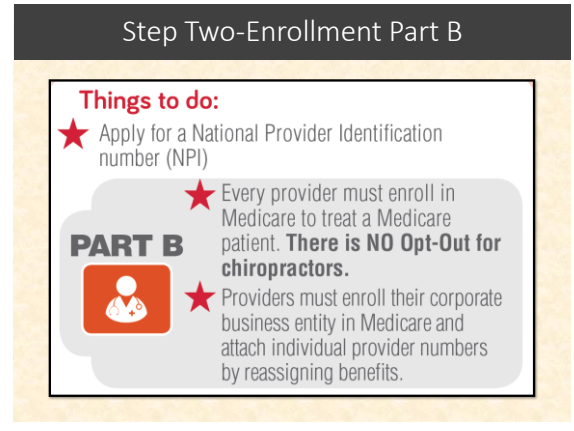
Step Two-Enrollment Part B



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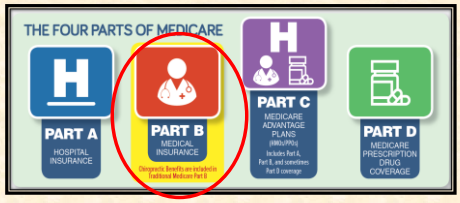
Types of Medicare Coverage: Part B

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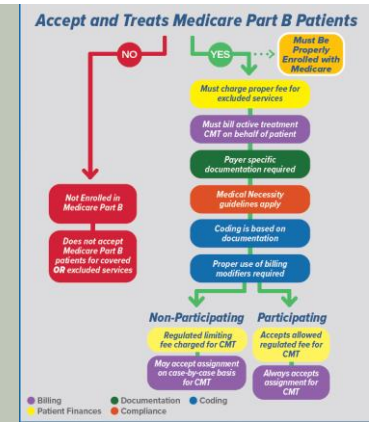
Obligations of DCs When Agreeing to Accept and Treat Medicare Part B Patients



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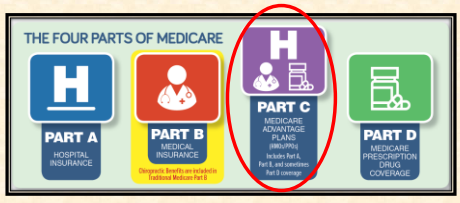
Types of Medicare Coverage: Part C

- 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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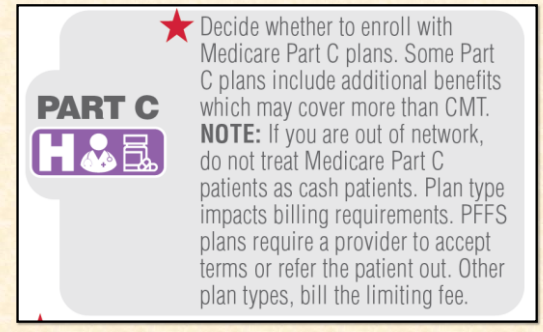
Step Three-Enroll in Part C Plans if Desired



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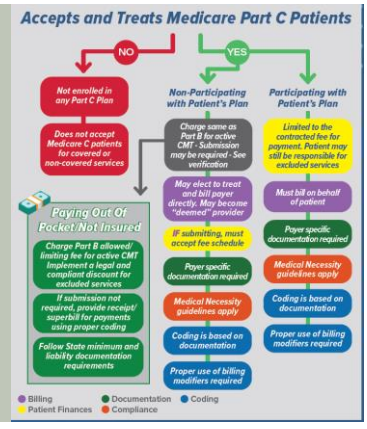
Obligations of DCs When Agreeing to Accept and Treat Medicare Part C Patients



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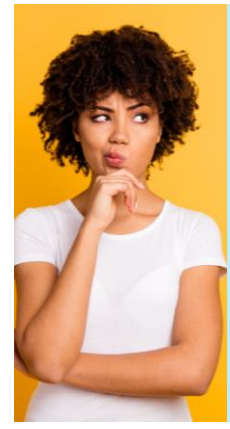


Important Considerations Each Visit

- 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!

42

Understand and Implement Medical Necessity Definitions

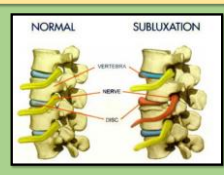
The definition of Medical Necessity, per Medicare, is: The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide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

43

44

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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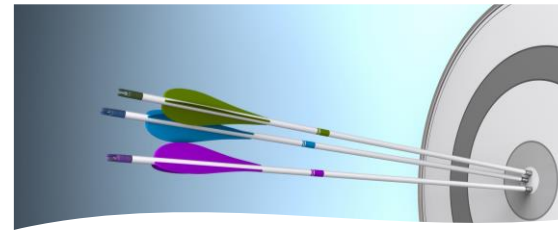


Denials Relate to Three Things

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

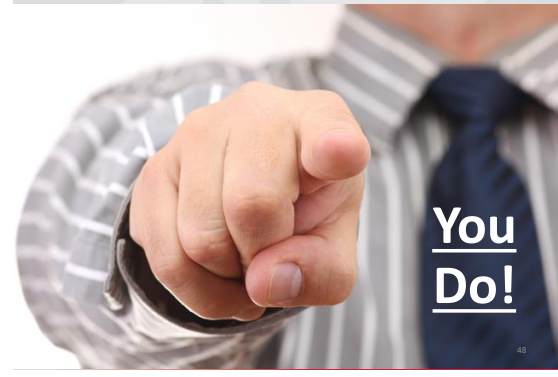
46

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

47

Who Determines Active vs. Maintenance?



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But You Have to Back it Up!

49

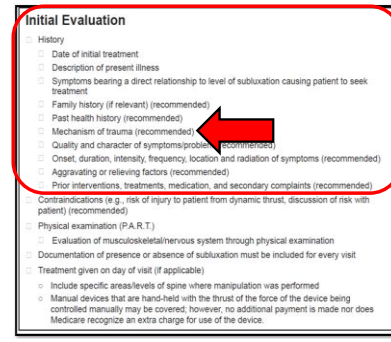
Documenting Medical Necessity in History or Subjective if Incident

- 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

50

51

Medicare Documentation Job Aid for Chiropractic Doctors



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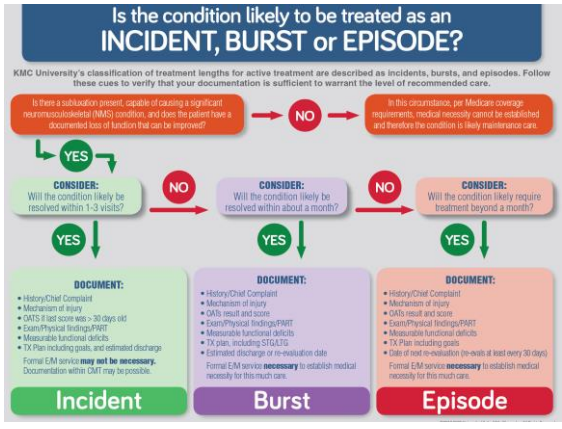

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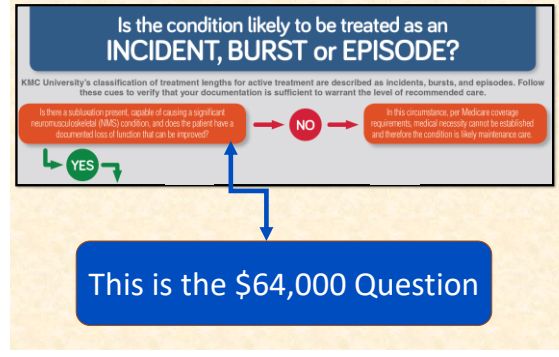
I know they need care…now what?



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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?

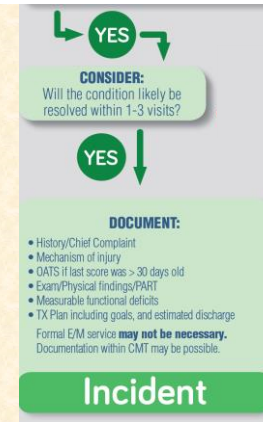
If No….

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

55

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



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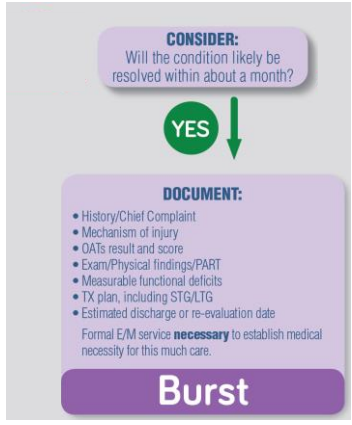

Burst may be the most common used

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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

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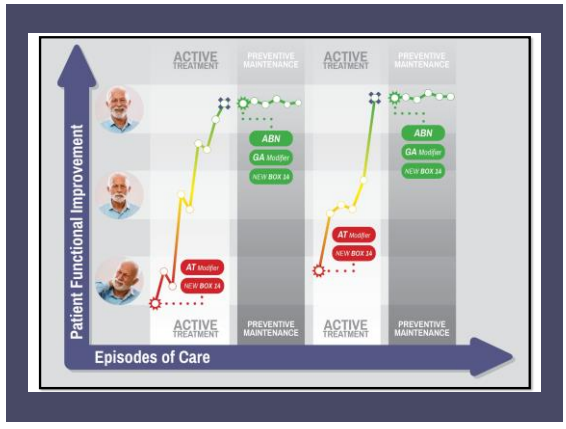

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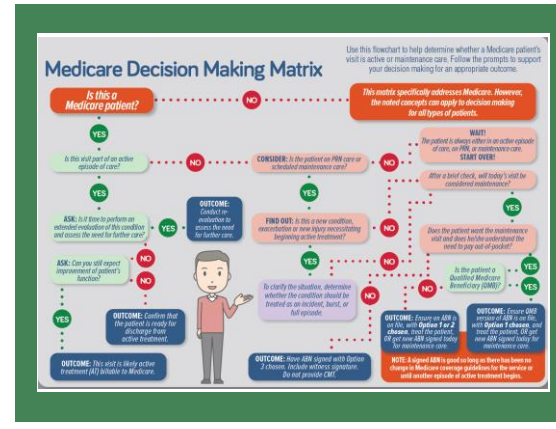

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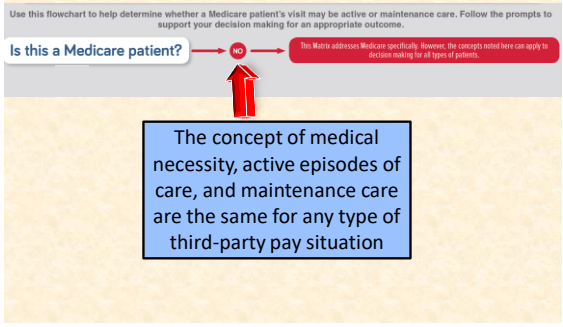
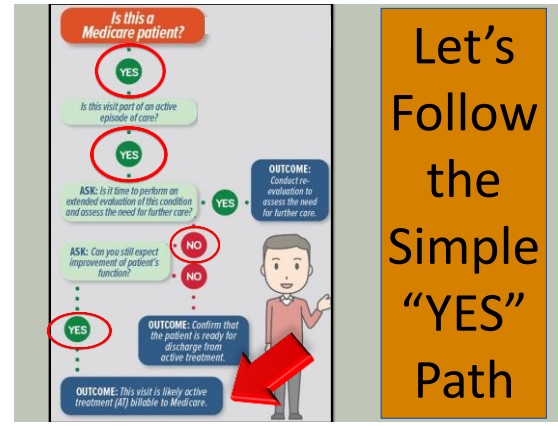
Not Medicare Only…



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

61



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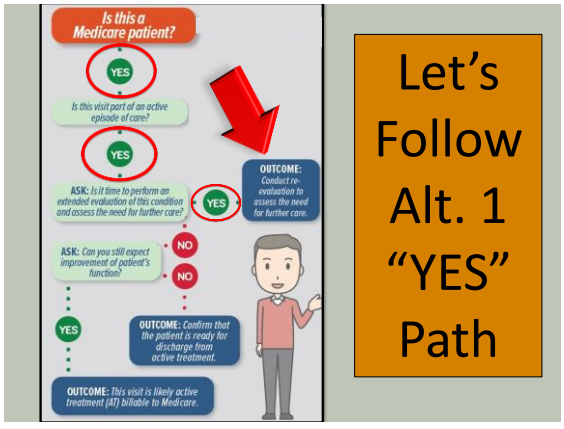

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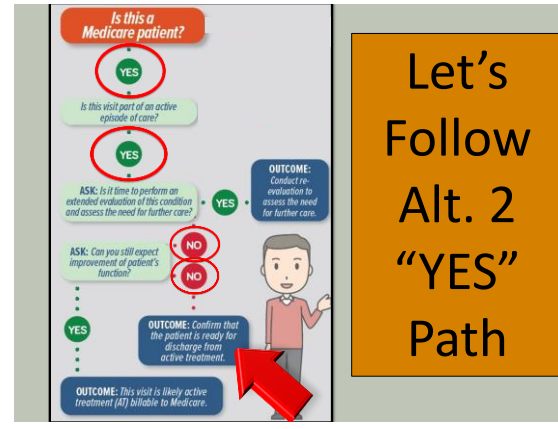

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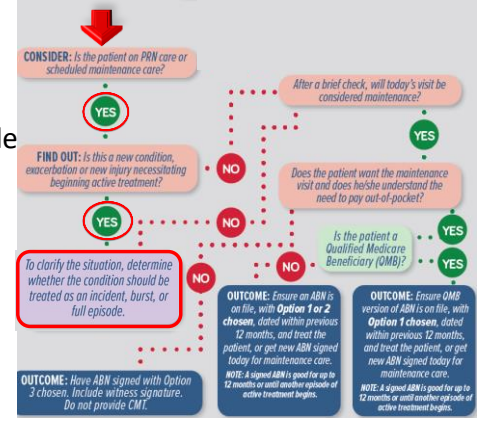
The New Episode Path



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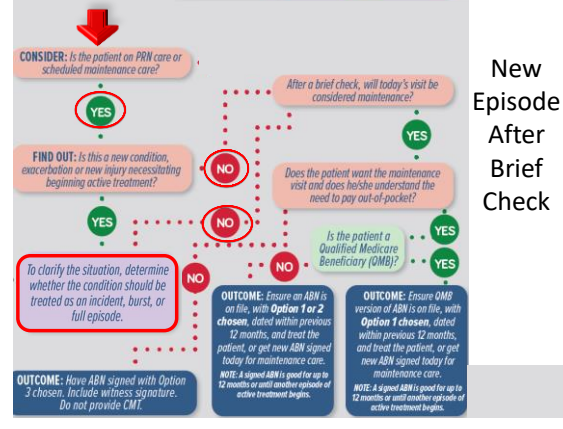

New Episode After Brief Check

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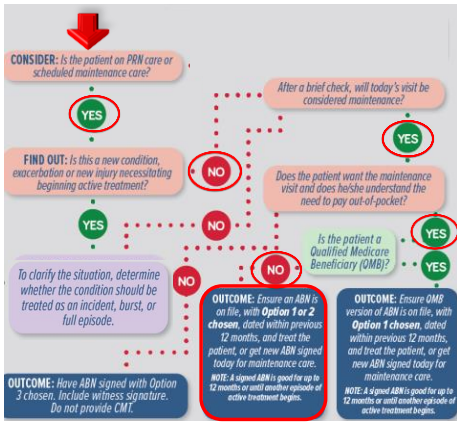

The True Non-AT Path Non-QMB

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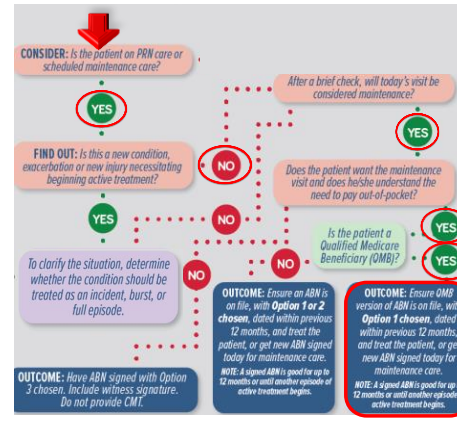

The True Non-AT Path For a QMB

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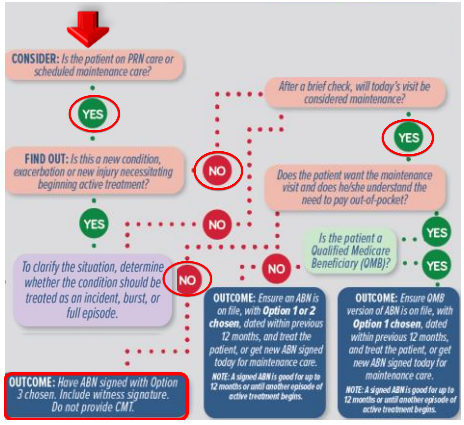

The Non-AT Path "No Thank You"

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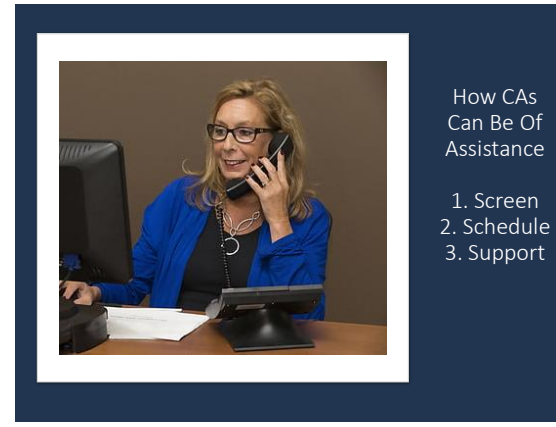

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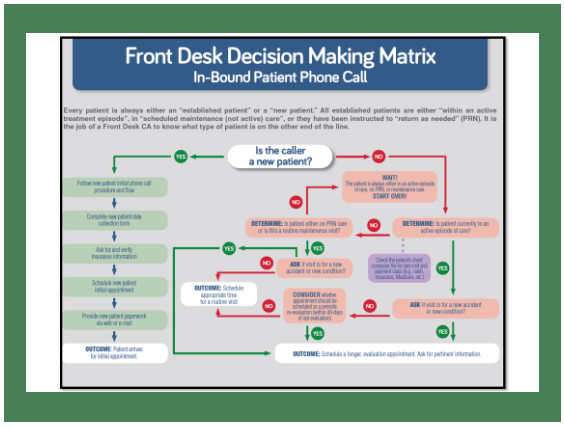

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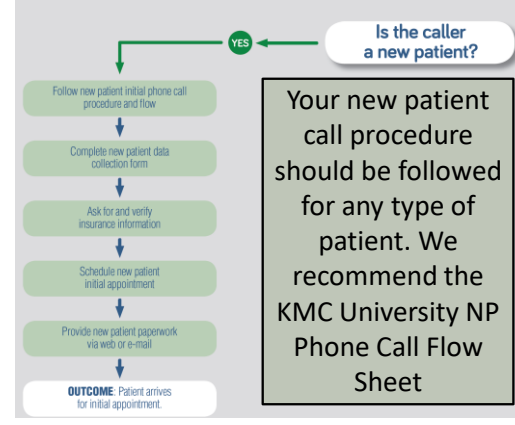

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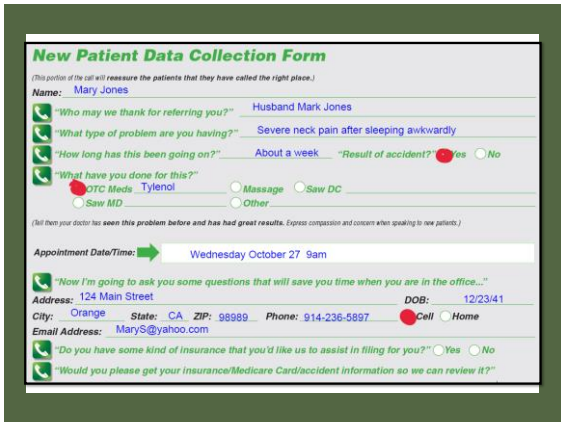

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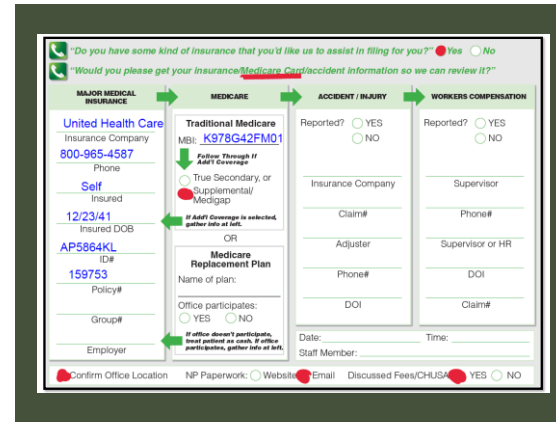

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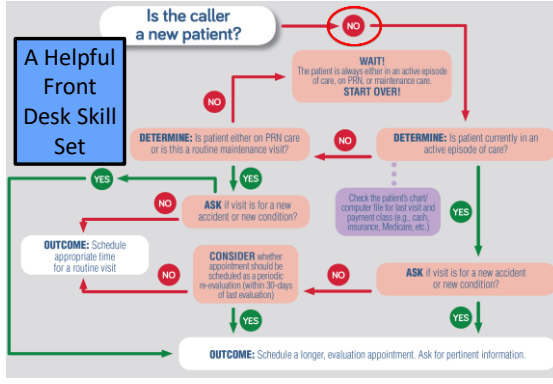

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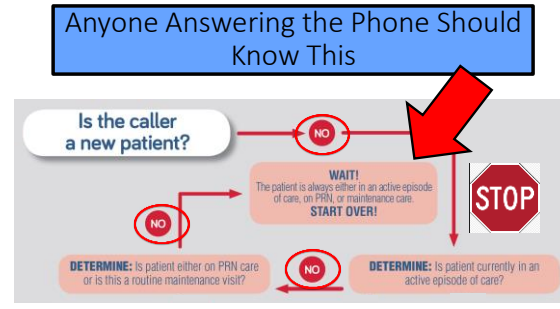

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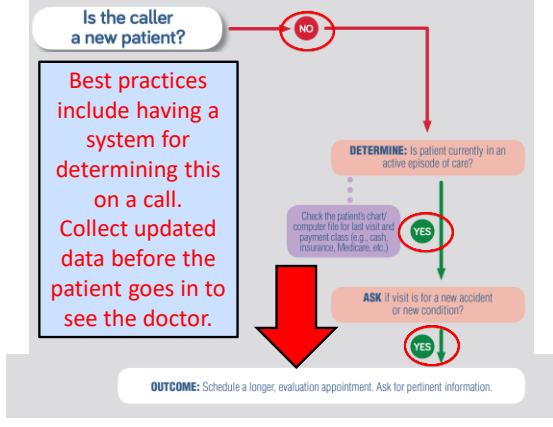

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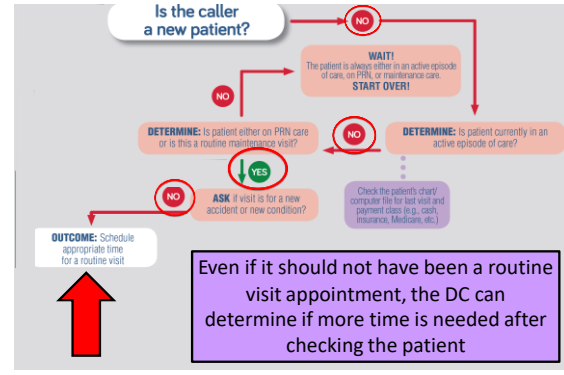

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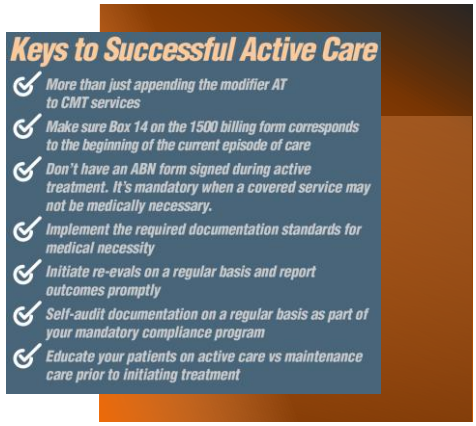


79

A Coding Primer

Procedure codes are represented by CPT and HCPCS

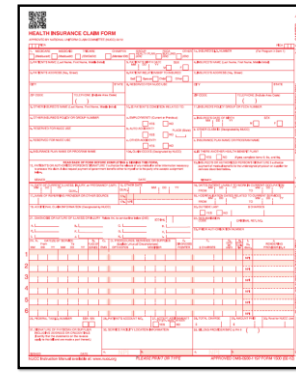
80

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

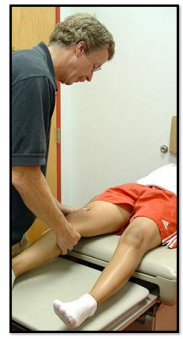
- Consistency – no matter who is paying for the service
- Objective– high-quality health data to payers
- Accurate– one that best describes the service(s)

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	Medically appropriate history and/or examination	Straightforward	15-29
99203		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	Medically appropriate history and/or examination	Straightforward	10-19
99213		Low	20-29
99214		Moderate	30-39
99215		High	40-54

87

Option 2- Code by Medical Decision Making

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	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*; ▪ review of the result(s) of each unique test*; ▪ ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment

Lower back pain and stiffness after moving a couch

No data to review, other than prior notes from previous episodes of lower back pain

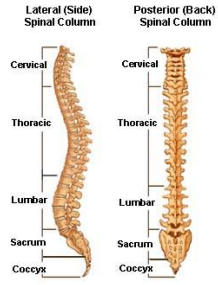
Low risk from manipulation and home exercise stretches

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

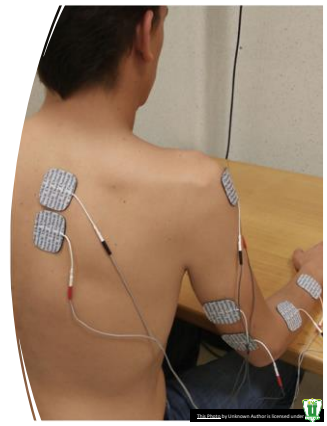
Constant Attendance Modalities:

- 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

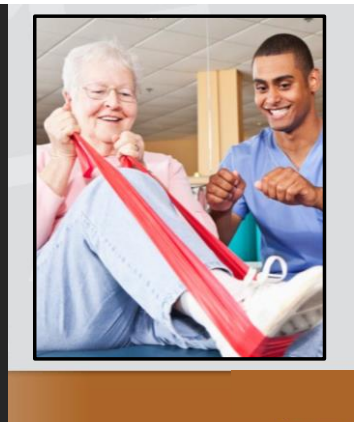
Exercise Services: Documentation and Intent

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

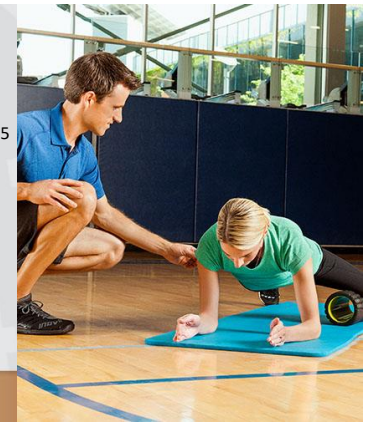


97

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

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)

Coding

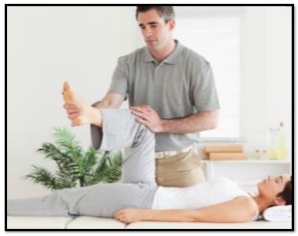
99

Therapeutic Exercises-97110

- 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

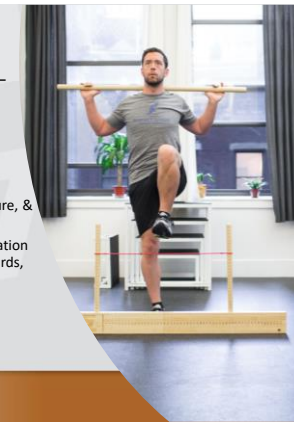
The CPT Knowledge Base responded as follows:

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), Feldenkreis, Bobath, BAP'S Boards, and desensitization techniques
- Most likely indicated for neurological conditions

Coding

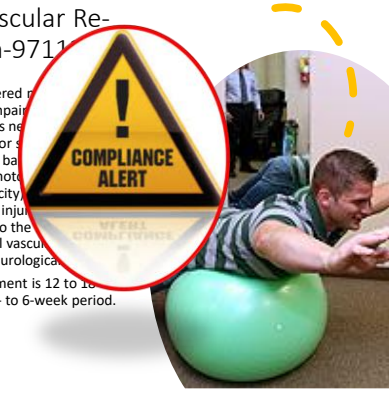
104

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-9711

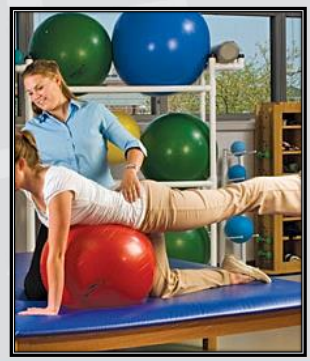


- May be considered n necessary for impair affect the body's ne system (e.g., poor s sitting/standing ba gross and fine moto hypo/hypertonicity from disease or injur severe trauma to the system, cerebral vascu and systemic neurologica
- Standard treatment is 12 to 1 visits within a 4- to 6-week period.

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 compliant 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

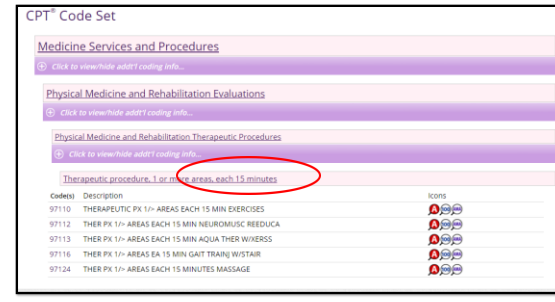
110

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"



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

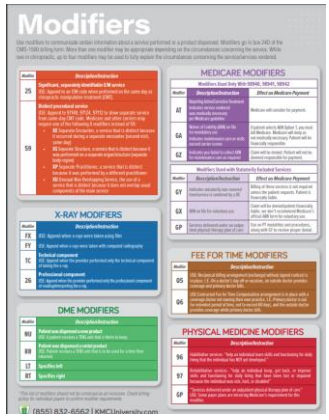
Coding Modifiers

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



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

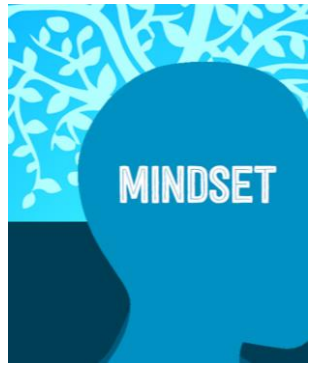
117

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

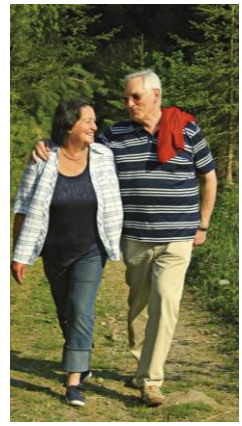
- Understand medical necessity guidelines, if any
- Patient history that supports orthotic necessity
- Description of the present illness including past treatment whether failed or effective
- Physical Exam of the affected area
- Diagnosis that meets the requirements in the MRP
- Treatment Plan that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



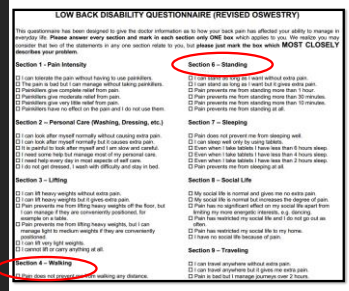
121

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!!

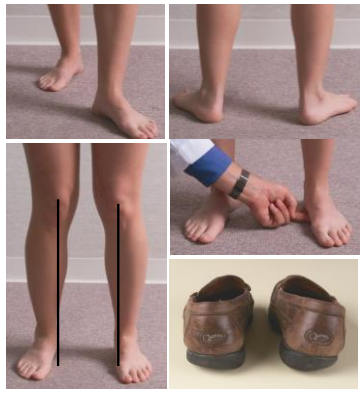

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

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

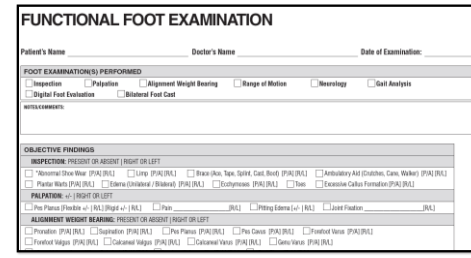
124



5 Red Flags

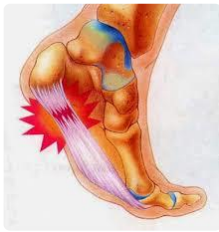
125

Sample Foot Exam


FUNCTIONAL FOOT EXAMINATION

126

Appropriate DX Codes



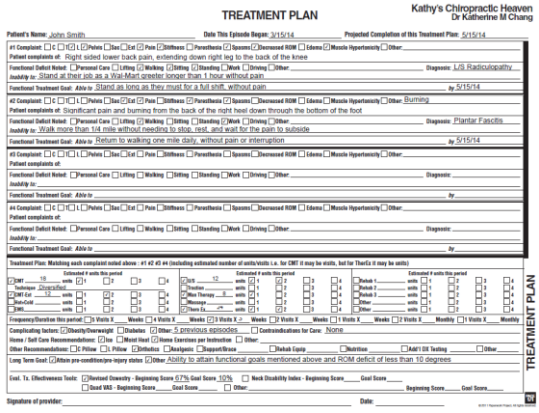
- Ensure the DX codes used are covered in the review policy if billing
- Spinal conditions may need to be sequenced secondary to extremity conditions
- The DX belongs in the initial visit documentation

127

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

128



TREATMENT PLAN

Kathy's Chiropractic Heaven
Dr Katherine M Chang

Patient's Name: John Smith Date This Episode Began: 3/15/14 Projected Completion of this Treatment Plan: 5/15/14

#1 Complaint: ☐C ☐T ☑L ☑Pelvis ☐Sac ☐Ext ☑Pain ☑Stiffness ☐Paresthesia ☐Spasms ☑Decreased ROM ☐Edema ☑Muscle Hypertonicity ☐Other:
Patient complaints of: Right sided lower back pain, extending down right leg to the back of the knee
Functional Deficit Noted: ☐Personal Care ☐Lifting ☑Walking ☑Sitting ☑Standing ☐Work ☐Driving ☐Other: Diagnosis: L/S Radiculopathy
Inability to: Stand at their job as a Wal-Mart greeter longer than 1 hour without pain
Functional Treatment Goal: Able to Stand as long as they must for a full shift, without pain by 5/15/14

#2 Complaint: ☐C ☐T ☑L ☐Pelvis ☐Sac ☑Ext ☑Pain ☐Stiffness ☑Paresthesia ☑Spasms ☐Decreased ROM ☐Edema ☐Muscle Hypertonicity ☐Other: Burning
Patient complaints of: Significant pain and burning from the back of the right heel down through the bottom of the foot
Functional Deficit Noted: ☐Personal Care ☐Lifting ☑Walking ☐Sitting ☐Standing ☐Work ☐Driving ☐Other: Diagnosis: Plantar Fascitis
Inability to: Walk more than 1/4 mile without needing to stop, rest, and wait for the pain to subside
Functional Treatment Goal: Able to Return to walking one mile daily, without pain or interruption by 5/15/14

#3 Complaint: ☐C ☐T ☐L ☐Pelvis ☐Sac ☐Ext ☐Pain ☐Stiffness ☐Paresthesia ☐Spasms ☐Decreased ROM ☐Edema ☐Muscle Hypertonicity ☐Other:
Patient complaints of:
Functional Deficit Noted: ☐Personal Care ☐Lifting ☐Walking ☐Sitting ☐Standing ☐Work ☐Driving ☐Other: Diagnosis:
Inability to:
Functional Treatment Goal: Able to by

#4 Complaint: ☐C ☐T ☐L ☐Pelvis ☐Sac ☐Ext ☐Pain ☐Stiffness ☐Paresthesia ☐Spasms ☐Decreased ROM ☐Edema ☐Muscle Hypertonicity ☐Other:
Patient complaints of:
Functional Deficit Noted: ☐Personal Care ☐Lifting ☐Walking ☐Sitting ☐Standing ☐Work ☐Driving ☐Other: Diagnosis:
Inability to:
Functional Treatment Goal: Able to by

Treatment Plan: Matching each complaint noted above : #1 #2 #3 #4 (including estimated number of units/visits i.e. for CMT it may be visits, but for TherEx it may be units)

	Estimated # units this period					Estimated # units this period				
☑CMT Technique Diversified	18 units	☑1	☐2	☐3	☐4	☑U/S	12 units	☑1		
☑CMT-Ext	12 units	☐1	☑2	☐3	☐4	☐Traction	units	☐1		
☐Hot+Cold	units	☐1	☐2	☐3	☐4	☑Man Therapy	8 units	☑1		
☐EMS	units	☐1	☐2	☐3	☐4	☐Massage	units	☐1		
						☑Thera Ex	24 units	☑1		

Frequency/Duration this period: ☐5 Visits X ____ Weeks ☐4 Visits X ____ Weeks ☑3 Visits X 2 Weeks
Complicating factors: ☑Obesity/Overweight ☐Diabetes ☑Other: 5 previous episodes ☐Contraindications for Care: None
Home / Self Care Recommendations: ☐Ice ☐Moist Heat ☑Home Exercises per Instruction ☐Other:
Other Recommendations: ☐C Pillow ☐L Pillow ☑Orthotics ☐Analgesic ☐Support/Brace ☐Rehab Equip ☐Nutrition ☐Add'l DX Testing
Long Term Goal: ☑Attain pre-condition/pre-injury status ☑Other: Ability to attain functional goals mentioned above and ROM deficit of less than 10 degrees
Eval. Tx. Effectiveness Tools: ☑Revised Oswestry - Beginning Score 67% Goal Score 10% ☐Neck Disability Index - Beginning Score ____ Goal Score ____
☐Quad VAS - Beginning Score ____ Goal Score ____ ☐Other: ____ Beginning Score ____ Goal Score ____

Signature of provider: ____ Date: ____

TM

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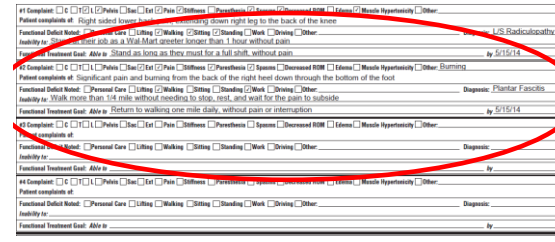

#1 Complaint: ☐C ☐T ☑L ☑Pelvis ☐Sac ☐Ext ☑Pain ☐Stiffness ☐Paresthesia ☐Spasms ☐Decreased ROM ☐Edema ☐Muscle Hypertonicity ☐Other:
Patient complaints of: Right sided lower back pain, extending down right leg to the back of the knee
Functional Deficit Noted: ☐Personal Care ☐Lifting ☑Walking ☑Sitting ☑Standing ☐Work ☐Driving ☐Other: Diagnosis: L/S Radiculopathy
Inability to: Stand at their job as a Wal-Mart greeter longer than 1 hour without pain
Functional Treatment Goal: Able to Stand as long as they must for a full shift, without pain by 5/15/14

#2 Complaint: ☐C ☐T ☐L ☐Pelvis ☐Sac ☑Ext ☑Pain ☐Stiffness ☑Paresthesia ☑Spasms ☐Decreased ROM ☐Edema ☐Muscle Hypertonicity ☐Other: Burning
Patient complaints of: Significant pain and burning from the back of the right heel down through the bottom of the foot
Functional Deficit Noted: ☐Personal Care ☐Lifting ☑Walking ☐Sitting ☐Standing ☐Work ☐Driving ☐Other: Diagnosis: Plantar Fascitis
Inability to: Walk more than 1/4 mile without needing to stop, rest, and wait for the pain to subside
Functional Treatment Goal: Able to Return to walking one mile daily, without pain or interruption by 5/15/14

#3 Complaint: ☐C ☐T ☐L ☐Pelvis ☐Sac ☐Ext ☐Pain ☐Stiffness ☐Paresthesia ☐Spasms ☐Decreased ROM ☐Edema ☐Muscle Hypertonicity ☐Other:
Patient complaints of:
Functional Deficit Noted: ☐Personal Care ☐Lifting ☐Walking ☐Sitting ☐Standing ☐Work ☐Driving ☐Other: Diagnosis:
Inability to:
Functional Treatment Goal: Able to by

#4 Complaint: ☐C ☐T ☐L ☐Pelvis ☐Sac ☐Ext ☐Pain ☐Stiffness ☐Paresthesia ☐Spasms ☐Decreased ROM ☐Edema ☐Muscle Hypertonicity ☐Other:
Patient complaints of:
Functional Deficit Noted: ☐Personal Care ☐Lifting ☐Walking ☐Sitting ☐Standing ☐Work ☐Driving ☐Other: Diagnosis:
Inability to:
Functional Treatment Goal: Able to by

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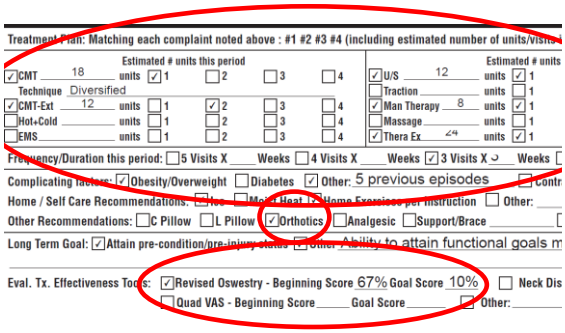

Treatment Plan: Matching each complaint noted above : #1 #2 #3 #4 (including estimated number of units/visits

	Estimated # units this period					Estimated # units				
☑CMT Technique Diversified	18 units	☑1	☐2	☐3	☐4	☑U/S	12 units	☑1		
☑CMT-Ext	12 units	☐1	☑2	☐3	☐4	☐Traction	units	☐1		
☐Hot+Cold	units	☐1	☐2	☐3	☐4	☑Man Therapy	8 units	☑1		
☐EMS	units	☐1	☐2	☐3	☐4	☐Massage	units	☐1		
						☑Thera Ex	24 units	☑1		

Frequency/Duration this period: ☐5 Visits X ____ Weeks ☐4 Visits X ____ Weeks ☑3 Visits X 2 Weeks
Complicating factors: ☑Obesity/Overweight ☐Diabetes ☑Other: 5 previous episodes ☐Contr
Home / Self Care Recommendations: ☐Ice ☐Moist Heat ☑Home Exercises per Instruction ☐Other:
Other Recommendations: ☐C Pillow ☐L Pillow ☑Orthotics ☐Analgesic ☐Support/Brace
Long Term Goal: ☑Attain pre-condition/pre-injury status ☑Other: Ability to attain functional goals m
Eval. Tx. Effectiveness Tools: ☑Revised Oswestry - Beginning Score 67% Goal Score 10% ☐Neck Dis
☐Quad VAS - Beginning Score ____ Goal Score ____ ☐Other: ____

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Complicating factors: ☑Obesity/Overweight ☐Diabetes ☑Other: 5 previous episodes ☐Contraindications for Care: None
Home / Self Care Recommendations: ☑Ice ☐Moist Heat ☑Home Exercises per Instruction ☐Other:
Other Recommendations: ☐C Pillow ☐L Pillow ☑Orthotics ☐Analgesic ☐Support/Brace ☐Rehab Equip ☐Nutrition ☐Add'l DX Testing
Long Term Goal: ☑Attain pre-condition/pre-injury status ☑Other: Ability to attain functional goals mentioned above and ROM deficit of less than 10 degrees
Eval. Tx. Effectiveness Tools: ☑Revised Oswestry - Beginning Score 67% Goal Score 10% ☐Neck Disability Index - Beginning Score ____ Goal Score ____
☐Quad VAS - Beginning Score ____ Goal Score ____ ☐Other: ____ Beginning Score ____

132

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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Recognize New Episodes With Ease

134

Introduction to Initial Visits—A 25,000ft. View

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

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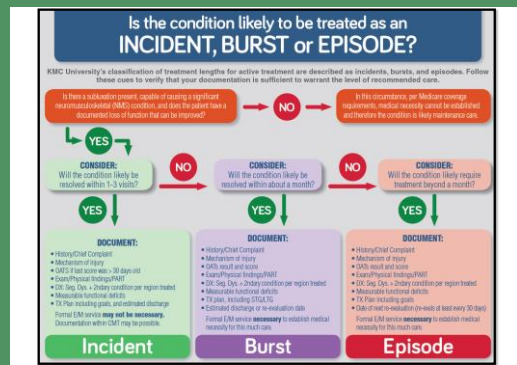

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What 3rd Party Payers Want to See

- 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

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Medicare Documentation Guidelines in the Absence of Others

Initial Visit

- History
- Description of Present Illness
- Physical Exam
- Diagnosis
- Treatment Plan
- Date of initial treatment

Subsequent Visits

- History
- Review of chief complaint
- Physical Exam
- Documentation of daily treatment
- Progress related to treatment goals/plan

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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

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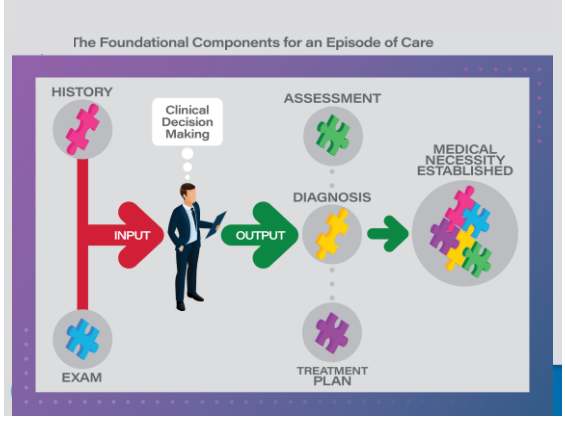
The Not-So-Easy Stuff

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

142



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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

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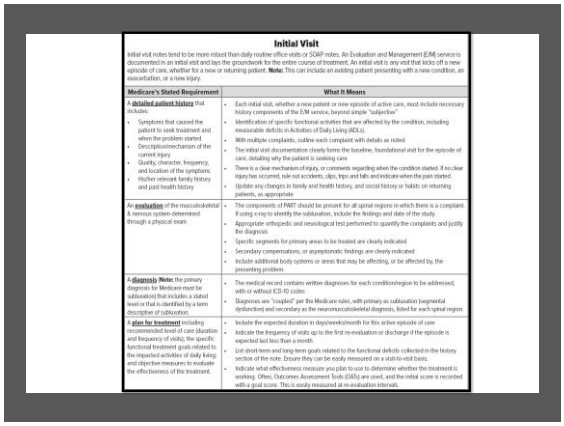

Initial Visit

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: • Symptoms that caused the patient to seek treatment and when the problem started • Description/mechanism of the current injury • Quality, character, frequency, and location of the symptoms • 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" • 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 initial visit 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 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. • 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. • Appropriate orthopedic and neurological test performed to quantify the complaints and justify the diagnosis • Specific segments for primary areas to be treated are clearly indicated • Secondary compensations, or asymptomatic findings are clearly indicated • 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 • 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 • Indicate the frequency of visits up to the first re-evaluation or discharge if the episode is expected last less than a month. • 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. • 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.

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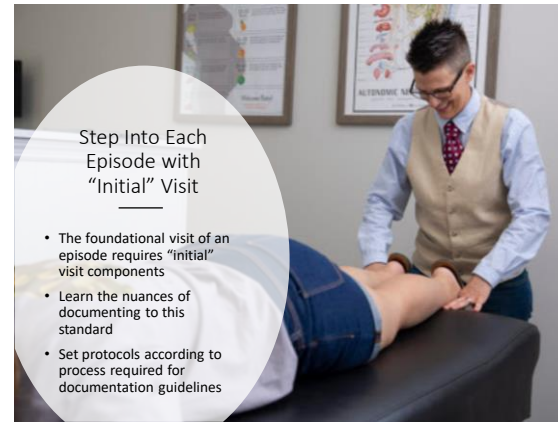

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The No Surprises Act Complexity

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

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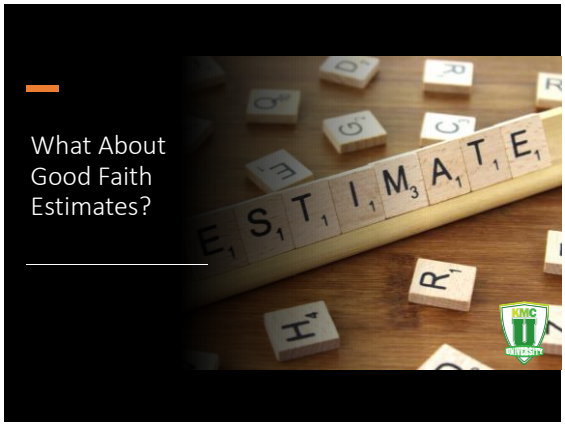

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"Health care providers and health care facilities are required under PHS Act section 2799B-6 to furnish a **notification of the good faith estimate of expected charges to an uninsured (or self-pay) individual** who schedules an item or service…"

Good Faith Estimate

150

Providers are defined as..

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

151

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"

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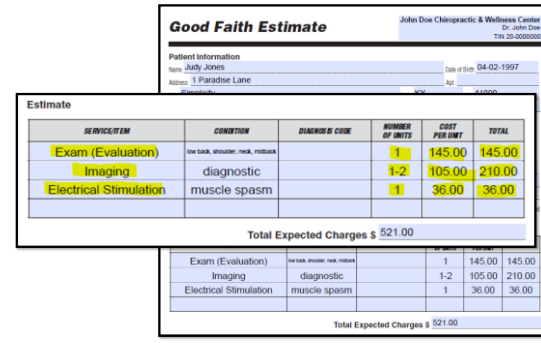

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New Patient Visit Customization with a Range

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

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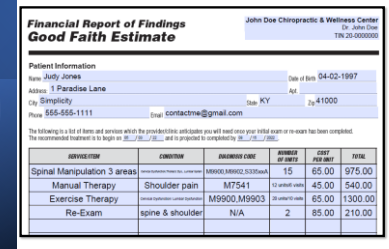
Second Step of the GFE Process



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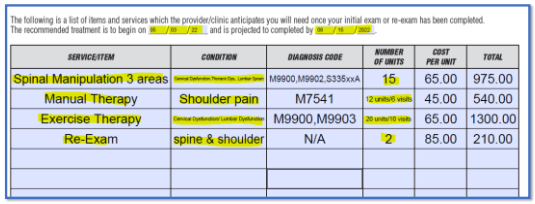
Treatment Plan from the DC



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 __/__/__ and is projected to completed by __/__/__.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Spinal Manipulation 3 areas		M9900,M9902,S335xxA	15	65.00	975.00
Manual Therapy	Shoulder pain	M7541	12 units/5 visits	45.00	540.00
Exercise Therapy		M9900,M9903	20 units/10 visits	65.00	1300.00
Re-Exam	spine & shoulder	N/A	2	85.00	210.00

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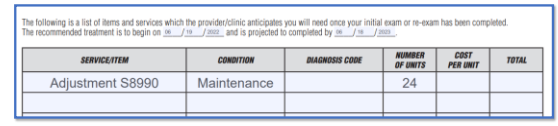
Maintenance Plan



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 __/__/__ and is projected to completed by __/__/__.

SERVICE/ITEM	CONDITION	DIAGNOSIS CODE	NUMBER OF UNITS	COST PER UNIT	TOTAL
Adjustment S8990	Maintenance		24		

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