Meeting the Medicare "Episode of Care"
With Mario Fucinari DC, CCSP®, APMP, MCS-P, CPCO
Sponsored by ChiroHealthUSA (2 Hours)

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About Dr. Mario Fucinari, CCSP®, APMP, CPCO, MCS-P

- Graduate of Palmer College of Chiropractic - 1986
- Currently in Full Time Practice in Decatur, Illinois
- Certified Chiropractic Sports Physician (CCSP) – Logan College of Chiropractic
- Certified Medical Compliance Specialist Physician – (MCS-P)
- Certified Professional Compliance Officer – CPCO (AAPC)
- Diplomate Academy of Integrative Pain Management (APMP)
- Post-graduate Faculty of Palmer College of Chiropractic, NYCC, D'Youville College, Life West and Western States Chiropractic College
- National Speaker's Bureau for NCMIC, ChiroHealthUSA and Foot Levelers and many state associations
- Member Medicare Carrier Advisory Committee
- Past President of Illinois Chiropractic Society (ICS)
- Chairman, ICS Medicare Committee
- ICS Chiropractor of the Year 2012
- Member of ACA and ICS

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Introduction

HUNDREDS OF MILLIONS IN MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES DID NOT COMPLY WITH MEDICARE REQUIREMENTS

"More than 90 days (approximately 3 months) between the date of initial treatment and the date of service, which may indicate that the services were maintenance therapy."

Why Documentation Matters.

- Risk Management for the Doctor
- Ensures Program Integrity for the Carriers
- Better Patient Safety and Outcomes

Documentation Red Flag:

- CLONING
- Over-documenting and Cloning

Only document what was done that day. No carry-over
Carry-Over = FRAUD

The Medicare "Episode of Care"

"Medicare may only pay for items or services that are "reasonable and necessary" for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member."

On the first encounter or in the case of a new injury, generate an "Initial Encounter Report"

The "Episode of Care"

Box 14:
Medicare –
Commercial Insurance –
PI/ Work Comp -

Medicare Initial Encounter Report

Symptoms causing patient to seek treatment
Family History
Past Health History
(Social History)
Mechanism of
Trauma
Quality and character of symptoms/problem
Onset, duration, intensity, frequency, location and radiation
Provoking and Palliative Factors
Prior interventions, treatments, medications, secondary complaints

Treatment Plan

- Recommended Level of Care
  Duration and frequency of visits
- Specific Treatment Goals
  What are you trying to accomplish?
- Objective measures to evaluate treatment effectiveness
  How do you know when the treatment has been accomplished?
- Care Plan

Chief Complaint – a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient's own words.

- Symptoms causing patient to seek treatment (Chief Complaint)
  - What brought the patient in?
    - Acute injury/trauma?
    - Chronic condition…why now?
- Prior level of function

Family History – specific health related events in the patient's family. Includes information about the health status or cause of death of parents, siblings, and children and the following diseases:

Orthopedic (arthritis, scoliosis) _____
Neurologic _____
Pathology (heart disease, cancer, diabetes)

The Big Five

Past Health history
- Prior Illnesses and injuries
- Type, date, treatment, current status
- Prior Interventions Type, date, treatment, outcome
- Prior Surgery Type, date, reason, results, current status
- Hospitalizations
- Prior trauma
  - Type, date, treatment, current status and extent of impairment
  - The most common mistake is not going back far enough when questioning about trauma or injury.
- Medications
- Allergies
- Immunization status
- Dietary status

Social History
- Marital status
- Employment history
- Occupational history
- Use of drugs, alcohol, tobacco
- Level of education
- Sexual history and social factors

Sitting is the New Smoking

The History of Present Illness (HPI)

L, M, N, O, P, Q, R,S,T

Mechanism of Trauma

Onset, duration, intensity, frequency, location and radiation
Box 14:

Qualifier:

Provoking and Palliative Factors
Prior interventions, treatments, medications, secondary complaints
Quality and character of symptoms/problem
Radiation of symptoms

Severity
Time

Review of Systems (ROS) – a series of questions of body systems that is used to clarify the differential diagnosis (Ddx) , necessary tests, or for baseline data.

Code 99203: 3-8 out of 13 must be present. **If NO ROS are present, then it is a 99201 code.**

ROS must document that you *reviewed* the systems with the patient. "Denies" or "Complains of" should be listed

Nurse's Code:
Example:
Cardiovascular: Denies: Shortness of breath, chest pain. Complains of: hypertension
Musculoskeletal: Denies: leg weakness or paresthesia. Complains of: right knee pain, right leg pain into the great toe

Most notes are in the SOAP format.

You can also use CHEDDAR (especially in Wisconsin!)

Chief complaint
History
Exam
Details
Drugs
Assessment
Return visit plan.

Subjective – What's going on?

- Reporting of patient pain, limitations, concerns and problems.
- Information that cannot be verified or measured during the encounter.
- You may want to use a quote or summarize what the patient reported.
- A well-done interview seems like a conversation on the surface.
- Address their symptoms
- Any change in palliatives or provoking?
- Has the quality, intensity or radiation of pain changed?
- Changes in ADL?
- Are they compliant with their home care?
- New injuries or new conditions?
- Any questions or comments?

Medicare SOAP

I. **History** (an interval history sufficient to support continuing need; document substantive changes)

Review of chief complaints (is this in relationship to the initial visit or treatment for the exacerbation)

Changes since last visit

System review if relevant

Railroad Medicare: Always address the following: _____

II. Physical Exam (interval; document subsequent changes; a full repeat of PART is not expected)

Exam of area of the spine involved in Dx.

Assessment of change in patient condition since last visit

Evaluation of treatment effectiveness

III. Evaluation of treatment effectiveness

In regard to the recommended level of care, duration, frequency and goals that were developed at the initial visit or at the time of exacerbation.

IV. Documentation of how the day's treatment fits within the plan of care (e.g. visit 4 of planned 7 treatments) and any way the treatment plan is being changed

You must document the actual segments that you adjusted.

Document the response to the adjustment. "patient tolerated treatment without incident"

Objective – What did you find?

- Reporting of all measurable, quantifiable, and observable data obtained during the encounter.
- Present a picture by reporting anything that the provider used their senses (vision, hearing, smell, touch)
- Does not depend on patient reporting.
- Make certain that it is clear that you were not just a *passive* observer in the visit.
- Remember that your documentation may be read by those unfamiliar with the shorthand that health professionals use so freely.
- Use judgment when using abbreviations and keep them standard.
- Include functional status and the positive *and significant negative* tests that you performed.

Under Part B Medicare, a chiropractor is "approved for treatment by means of manual manipulation of the spine to correct a subluxation.

P.A.R.T. PROVES A SUBLUXATION EXISTS

P.A.R.T.

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned under the above physical examination list are required, one of which must be asymmetry/misalignment or range of motion abnormality.

(2 of the 4 Required)

1. Pain/Tenderness - location, quality, intensity

   Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation, provocation, etc. Furthermore pain intensity may be assessed using one or more of the following: visual analog scales, algometers, pain questionnaires, etc.

2. Asymmetry/misalignment - sectional or segmental level

   Asymmetry/misalignment - Asymmetry/misalignment may be identified on a sectional or segmental level through one or more of the following: observation (posture and gait analysis), static palpation for misalignment of vertebral segments, diagnostic imaging, etc.

3. Range of Motion Abnormality

   Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and Range of motion abnormality - Range of motion abnormalities may be identified through one or more of the following: motion, palpation, observation, stress diagnostic imaging, range of motion measurements, etc.

4. Tissue, tone changes in skin, fascia, muscle, ligament

   Tissue, tone changes using descriptions pertaining to the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament. Tissue/Tone texture may be identified through one or more of the following procedures: observation, palpation, use of instruments, tests for length and strength etc.

Clinical Examples:

Evaluation and Management (E/M) CPT Codes

99201-99205/99211-99215

New patient vs. Established patient

New patient is a patient never treated in the office or not in the last three years.
The same degree of familiarity is applied for a doctor who is on call for you.
*New Patient codes: 99201-99205
*Established Patient Codes: 99211-99215

Key Components

- **History**
- **Examination**
- **Medical decision making**

Contributing Components

- Counseling
- Coordination of care
- Nature of presenting problem; and
- Time

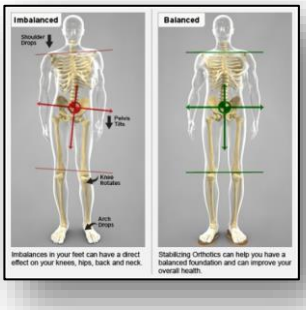
History:

- Chief complaint
- HPI
- ROS
- PFSH

The Examination:

On the initial examination or if significant, on subsequent visits, note the following:

- Visual Inspection (posture and skin)
- Patient build
- Carriage and gait cycle
- Patient movement
- Examine the shoes
- Scoliosis
- Antalgia
- Skin appearance
- Biomechanical Inspection



In summary, the physical exam should include:

- Visual Inspection
- Orthopedic and neurologic tests
- Palpation findings
- Pinprick sensitivity tests
- Reflexes
- Range of Motion - Give plane and degrees so it can be referenced later to show progress. The more specific the degrees, the better. Note pain.
- Muscle strength
- Outcome Questionnaires

Function Begins from the Ground Up!!

Medical Decision Making – MDM (Using Your Brain)

Evidence-Based Outcomes Assessment Tools (OATS)

Functional Impairment Rating

Why Outcomes Assessment?

- An objective measure of the patient's status
- Provides objective documentation regarding the patient's condition.
- Helps the doctor, patient and insurer to make *informed* decisions
- A deterrent to malpractice
- Backed up by refereed journals (JMPT, Spine)

Outcomes Assessment Tools

- Have patient complete on initial exam, on re-exam as clinically indicated and at any exacerbations.
- These tests *quantify* the amount of patient deconditioning present.
- A measure of the patient's **functional** impairment of activities of daily living.

Outcome Assessment Tests

- Visual Analog Scale
- Pain Drawings
- Revised Oswestry Low Back Pain Disability Questionnaire
- Roland-Morris Disability
- Neck Pain Disability Index Questionnaire
- Headache Disability Index
- Bournemouth Questionnaire – Cervical and Lumbar. "Lifestyle illnesses"
- Zung Psychological Assessment Questionnaire

Neck Pain Disability Index Score
0-8% = None
10-28% = Mild
30-48% = Moderate
50-68% = Severe
>70% = Crippled

Revised Oswestry Score:
0-5% = None
6-20% = Mild
20-40% = Moderate
40-60% = Severe
60-80% = Crippled
80%+ Bed Bound

*If you compare the original score to the score at re-examination, there must be a minimum of a 30% decrease in score to be clinically significant.

Re-Examination
- Formal re-examination should be done "to determine progress and need for further care"
- Should be done at least every 10-15 visits or every **30**-45 days. Medicare is every 30 days.
- Recheck all positive findings and significant negative findings.

A re-examination should include
- A brief consultation about current condition
- Repeat of significant orthopedic and neurologic tests
- Visual Analog Scale or Borg Scale
- Outcome measures test repeated

MEDICARE Re-evaluations ***NEW!***
Demonstrate the patients' progress in objective, rather than conclusory terms
The evaluation elements, noted in the initial evaluation need not be documented at each treatment; however, they must be present often enough to show measurable progress, or failure to progress

After the re-examination, update record with an interim note or report. This will document and explain the clinical significance of why you did the exam (rationale) and the results of the exam. This then leads to your treatment plan and treatment goals.

Assessment – What do you think?
- Provider records their professional opinions and judgments as to the patient's diagnosis, their progress and/or their functional limitations.
- You interpret the data presented in the objective portion of the note.

- You may also point out inconsistencies, justify your goals, discuss emotional status or indicate progress in therapy.
- You may also present reasons why certain information was not obtained or deferred.
- Recommendation of further tests or treatment that you think is necessary.
- Recommendation of referral to another provider.
- Do not introduce new data here.
- This is the area where you record *your* thought processes and concerns.

What is Medical Necessity? In your assessment, answer the following:
How is the patient improved?
Why does the patient still need care?

Medicare Medical Necessity

1. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services must have a direct therapeutic relationship to the patient's condition. (Medicare does not pay for pain).

2. You must have a reasonable expectation of recovery or improvement of function.

3. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam. A diagnosis of pain is not sufficient for medical necessity

Acute subluxation - treatment for a new injury, identified by x-ray or physical exam. The treatment is expected to improve, arrest, or retard the patient's condition.

Chronic subluxation - A patient's condition is considered chronic when it is not expected to completely resolve (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the functional status has remained stable for a given condition, further manipulative treatment is considered maintenance therapy and is not covered.

An **acute exacerbation** is a temporary but marked deterioration of the patient's condition that is causing significant interference with activities of daily living due to an acute flare-up of the previously treated condition. The patient's clinical record must specify the date of occurrence, nature of the onset, or other pertinent factors that would support the medical necessity of treatment. As with an acute injury, treatment should result in improvement or arrest of the deterioration within a reasonable period of time.

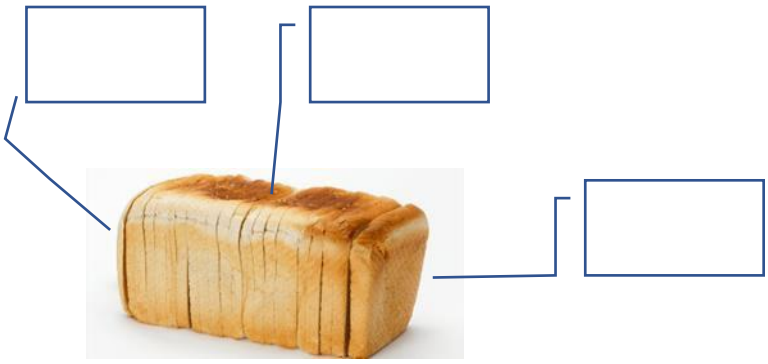
Maintenance Therapy

Once MMI has been reached, Medicare will NOT pay for maintenance or supportive care.

___ Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or ____ maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3A)

1.

2.



"The Episode of Care" Model

Treatment Plan

What are you going to do about it?

- Individualized
- Patient-centered goals
- Realistic
- Reasonable time-frame
- Tolerance

Treatment Plan:

1. Treatment Frequency AND Duration

2. Treatment Goals
   a) Short-term Goals
      To decrease pain, spasms and edema
      Resolution of any radicular pain in the lower extremity
      Low back pain consistently less than or equal to 6/10 with all activities
      Resting low back pain with less than or equal to 2/10
      Independent with basic self-care ADL without increased low back pain

   b) Long-term Goals
      Address their ADL
      Low back pain at worst less than or equal to 4/10 with all activities
      Patient will ambulate 15 minutes at 2.0 miles per hour without increased low back pain
      Bilateral hip flexion, multifidus and gluteal strength to 4+ to 5/5
      Independent self-management
      To prepare the patient for a home-based exercise program

3. Care Plan

Example:
In the acute stage: manipulation, EMS (unattended), ice, pulsed ultrasound and patient education as indicated

In the sub-acute stage: manipulation per palpation, skilled therapeutic rehabilitation exercise to improve functional capacity, strength and endurance and to decrease pain with ADL and patient education as indicated

Specific Treatment Goals

What are you trying to accomplish?

Objective measures to evaluate treatment effectiveness

How do you know when the treatment has been accomplished?

Recommended Level of Care

Duration and frequency of visits to accomplish the above goals

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Medicare can now ask for records from up to FIVE years ago. Are you complaint? The OIG stated that a compliance plan (different from HIPAA) is a mitigating factor against fines and/or jail time. If you have a Compliance Plan done in keeping with the OIG Recommendations, it may be your bullet-proof vest!

For a *professionally* created Compliance manual, unique to your office or chart audits contact Mario Fucinari DC, CCSP, CPCO, a **Certified Professional Compliance Officer** for further information.

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www.AskMario.com
E-mail: Doc@AskMario.com

Thank You!!

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

OMB APPROVAL PENDING