Let’s Get Down to Business Series

RECORD KEEPING, DOCUMENTATION & CODING

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We do not set practice standards. We offer this only to educate and inform.

Thank you to my mentor

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How long do you need to keep records?

- It is interesting to note that HIPAA rules and regulations do not include medical record retention requirements. Rather, other federal and state laws regarding record retention apply.

- HIPAA rules do require that you utilize appropriate administrative, technical, and physical safeguards to protect the privacy of information for as long as you maintain records.

- Our guidance at the WCA Help Desk is to retain medical records, including electronic records for at least seven years. This is because the regulations defining "unprofessional behavior" of a chiropractor contained within the Wisconsin Administrative Code include, "Failing to maintain records for a minimum period of 7 years after the last treatment or after the patient reaches the age of majority, whichever is greater." Wis. Admin. Code Chir. 6.02(27). For the complete statutes, visit: http://docs.legis.wisconsin.gov

- The American Health Information Management Association (AHIMA) recommends providers keep adult patient health records for 10 years after the most recent encounter. For minors, the recommendation is until the age of majority plus the statute of limitations. Because electronic records make longer periods of storage possible, you could exceed these guidelines. However, please note that if you keep records, you must produce those records when asked. Furthermore, the longer you keep records beyond the recommended retention period, the greater chance those records will be subject to a breach that may then require you to report to the individuals affected by the breach.
How long should you keep medical records?

<table>
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<tr>
<th>Type of Record</th>
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<td>7 years after last treated</td>
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</tr>
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</table>
Documentation

• Provides clear evidence of continuity of care to communicate with other providers
• Acts as a legal recording of the care given
• Supports the billing for services rendered

Is your documentation a weakness to be exploited by those who do not want to pay?
Or, is it a shield that protects you from liability and audits?

Denials

• Payers often believe that services rendered were unnecessary because:
  • There were too many visits
  • There were too many (or the wrong) services at each visit
  • Billing does not match documentation

• Good documentation can prove that:
  • The visits were medically necessary
  • The services were needed to help the patient get better
  • The billing is an accurate reflection of the record
Chiropractic Services Targeted

- 2018 CERT Improper Payment Report
  - 54.1% of chiropractic claims were paid improperly
  - 92.2% of those improper payments were due to insufficient documentation
- 20178Palmetto GBA: Payment error rate 84.4%

Auditors favorite targets

- Illegible records
- Missing dates
- Missing signature
- Missing informed consent
- Missing re-assessment
- Missing patient identifiers
- Missing metas/subjective
- Blanks used to indicate "WNL"
- Missing legend for abbreviations
- Missing care plan
- Cloned records
- Billing only 99240,99241
- Using travel cards

Cloned records
Bad Records

Bad records are:
- Most common cause of state board action in US
- Most common reason for claim payment denial
- Most common source of administrative heartburn
- Largest source of miscommunication between payers and the doctors

Problem Oriented Medical Record

1. Why did the patient begin care?
2. What did the provider find wrong?
3. What did he/she do about it?
4. How did care end?

Problem Oriented Medical Record

1. Complete problem list
2. Diagnoses for each problem
3. Treatment goals for each problem
4. Written treatment plan for each problem
5. SOAP notes for ongoing treatment of each problem
6. Date of resolution or referral for each problem

My "Southern" Family
Medicare Modifiers

It is Critical for every office to clearly understand the proper use of Modifiers. Currently, the only covered codes by Medicare are CMT Codes (98940, 98941, and 98942). When they are "Medically Reasonable and Necessary"

Medicare Modifiers

Here are the basics for coding and billing modifiers

AT Modifier appended to Spinal CMT

Active Treatment for the corrective phase of acute or chronic care. The Provider is informing Medicare that the provided treatment was for the definition of medical necessity. The AT is required as of October 1, 2004 for active treatment 98940, 98941, 98942 and is meant to represent the fact that the care was medically necessary under Medicare guidelines. It would never be used on maintenance care. Please make sure you understand the Medicare definitions of acute, chronic, and maintenance care.

Medicare Modifiers

Here are the basics for coding and billing modifiers

GA Modifier appended to Spinal CMT

Your Declaration that a Waiver of Liability Statement (for Medicare, this is the ABN) has been properly delivered as required by payer policy. The Advance Beneficiary Notice (ABN) is the form that is used when a covered service (spinal manipulation) is expected to be denied due to lack of medical necessity. If the treatment of a Medicare beneficiary’s maintenance care and therefore would be considered not medically necessary and not reimbursable by Medicare, you would have the patient sign an ABN and are required to append the GA modifier.

Medicare Modifiers

Here are the basics for coding and billing modifiers

NO Modifier Appended

When no Modifier is used, this indicates Maintenance care. Without appending an appropriate modifier, neither Medicare of the Patient would be responsible for payment of this Service.
Medicare Modifiers

Here are the basics for coding and billing modifiers:

**GZ Modifier appended to Spinal CMT**

You failed to deliver a mandated ABN, as is required by payer policy. In such cases, the patient does not have to pay. Please note that some providers have reported that the use of this modifier results in an AUDIT.

Use this modifier when an ABN should have been signed, but wasn’t. This modifier is a measure of good faith towards Medicare that you recognize you made an error. Please note that you may NOT collect payment from the patient.

**GY Modifier appended to Spinal CMT**

Must be appended to all statutorily non-covered services to ensure the claim will deny per Medicare policy. A Denial may be necessary 1.) to allow for appropriate billing of supplemental/secondary insurance or if the patient has requested to be non-covered, and 2.) to continue their denial for evidence of non-coverage.

This modifier is required for many services other than manual manipulation of the spine, including x-rays, exams, therapy modalities, and exams. Please note that you do not use GY on maintenance care spinal-CMT.

**GX Modifier appended**

Stem or service expected to be denied because it is not a covered service—ABN signed.

Modifier GX went into effect April 5, 2010. The GX modifier will be used when providers want to indicate they have used an ABN to voluntarily notify a beneficiary that a statutorily non-coverage Medicare service will not be covered. It is important to remember that the ABN is required when a service is “not reasonable and necessary” (e.g., maintenance care spinal-CMT, which are not required to inform patients that non-covered services [e.g., exams, x-rays, physical medicine services] will not be covered.)
Medicare: Documentation Requirements

- Medicare's documentation requirements are very specific, and it is possible to meet the requirement for documenting a subluxation within your daily chart notes. You must use the common sense approach to documentation. What may be appropriate documentation for one visit may not be adequate in another when other factors are taken into consideration such as frequency, duration of condition, severity of condition, past history, other documentation, etc.

Medicare sources have indicated that in a records review process, these are some of the questions that will be asked about your records, giving consideration to the combined documentation of the initial and subsequent visit(s):

- Does the record show a significant neuromusculoskeletal condition?
- Is there a precise subluxation(s) documented by physical exam or x-ray?
- Does the exam substantiate the condition and the subluxation(s)?
- Is there a primary diagnosis of subluxation and a secondary ICD condition caused by the subluxation(s)?
- Is there a treatment plan?
- Is the adjustment clearly recorded in the record as being done each visit?
- Is the adjustment therapy or maintenance (maintenance is non-covered by Medicare)?
- Is the adjustment therapeutic or maintenance (maintenance is non-covered by Medicare)?
- Is there a response to the adjustment noted in the records (increased ROM, increased function, decreased pain, etc. that show quality, character, and intensity that would qualitatively and quantitatively substantiate need and frequency of treatment)?
The Consultation

- Symptoms causing patient to seek treatment (Chief Complaint)
- FYI: 99203 should show PHx, Family Hx, Social Hx
- Family History
- (Demonstrate Later)

Documentation Requirements: History

- The history recorded in the patient record should include the following: Symptoms causing patient to seek treatment;
- Patient history
  - Chief complaint
  - Patient symptoms why seeking chiropractic treatment
  - Where, what, how, when, why?
  - What brought the patient in? what was cause? (MOI)
  - Prior level of FUNCTION? What are changes in Function?
  - Has patient had prior chiropractic treatments?
  - Symptoms are direct relationship to subluxation level

The Consultation

Present illness may include:

\[ \text{M, O, P, Q, R, S, T} \]

Mechanism of trauma, quality and character of symptoms/problem;
Onset, duration, intensity, frequency, location and radiation of symptoms;
Aggravating or relieving factors;

The Consultation

- Mechanism of Trauma
- Onset, duration, intensity, frequency, location and radiation
The Consultation

- Provoking and Palliative Factors
- Prior interventions, treatments, medications, secondary complaints

The Consultation

- Quality and character of symptoms/problem
- Radiation of symptoms

The Consultation

- Severity
- Time
  - Prior interventions or treatments; including medications
  - Secondary complaints

Previously under Care of a chiro?

Primary Medical Physician?
Treating What Conditions??
Postural:
- Examination of the posture shows the pelvis to be prominently antverted. The posterior superior iliac spines are evenly bilaterally. The anterior superior iliac spine is elevated bilaterally. The left scapula is elevated relative to the right. Both shoulders are internally rotated and there is marked tenderness and spasm to the pectoral musculature bilaterally. There is no tightness or tenderness to the left serratus anterior, with no tightness or tenderness to the right serratus anterior. The head and neck are held anterior of the mid-coronal line by 10°, but are well positioned in the mid-sagittal plane. There is a loss of the cervical lordosis. There is an increase in the thoracic kyphosis.

Gait:
- Romberg's test is negative. Gait is normal. Tandem, toe, and heel walking are normal.

Cranial Nerve Examination:
- Cranial nerves II, pupils are equal, round and reactive to light. Fundoscopic examination reveals sharp disc margins bilaterally with mild venous pulsations present bilaterally. Fields are full to confrontation without extinction. III, IV, and VI show full extra ocular movements without nystagmus or diplopia. V shows normal corneal reflexes. Muscles of mastication are normal. VII shows normal facial symmetry. VIII shows grossly normal hearing. Weber and Rinne are normal. IX and X, the uvula elevates in the midline. There is a good gag reflex bilaterally. There is no dysphonia and no dysarthria. XI, trapezius and sternocleidomastoid are normal bilaterally. XII, the tongue protrudes in the midline. There are no fasciculations or atrophy. Cranial nerves are normal.

Mental Examination:
- Examination of the mental states reveals the patient to be alert, appropriate and fully oriented. A formal mental status exam was not performed at this time.

Documentation Requirements: History

- 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 (RA), scoliosis)
    - Neurologic (MS)
    - Pathology (heart disease, cancer, diabetes)

- Past Health History
  - General health
  - Prior illness
  - Injuries
  - Hospitalizations
  - Medications
  - Allergies
  - Surgical history

The BIG FIVE

- Father to son
- Mother to daughter
- The multiply effect
Complicating Factors

Patient Characteristics
- Older age
- Pregnancy
- Psychosocial factors
- Delay treatment >7 days
- Non-compliance
- Lifestyle habits
- Obesity
- Type of work activities

Injury Characteristics
- Severe initial injury
- >3 previous episodes
- Severe signs and symptoms
- Number/Severity of previous exacerbations
- Treatment withdrawal fails to sustain MTI [Maximum tolerable intensity]

Complicating factors that may document the necessity of ongoing care for chronic conditions.
- Severity of symptoms and objective findings
- Patient compliance and/or non-compliance factors
- Factors related to age
- Severity of initial mechanism of injury
- Number of previous injuries (N3 episodes)
- Number and/or severity of exacerbations
- Psychosocial factors (pre-existing or arising during care)
- Pre-existing pathology or surgical alteration
- Waiting >7 days before seeking some form of treatment
- Ongoing symptoms despite prior treatment
- Nature of employment / work activities or ergonomics
- History of last time
- History of prior treatment
- Lifestyle habits
- Congenital anomalies
- Treatment withdrawal fails to sustain MTB [Maximum therapeutic Benefit]
• Social History
  - Marital status
  - Employment history
  - Occupational history
  - Use of drugs, alcohol, tobacco
  - Level of education
  - Sexual history and social factors

The Consultation
• Past Health history
  - Prior Illness
    - Type, date, treatment, current status
  - Prior Interventions
    - Type, date, treatment, outcome
  - Prior Surgery
    - Type, date, results, current status

General Health
• What’s been going on recently in your life?
• How do you Feel Normally?
• Pleasant/distressed

Mental Status (EMT.. Alert X4)
• Oriented x 1 = awareness of person
  - Sometimes, a person is oriented only to himself. That means he knows who he is but can’t recall or recognize anyone else—for example, who they are or what their names are.
• Oriented x 2 = knowledge of place
  - Location may include general awareness of where the person is, such as a city or state.
• Oriented x 3 = knowledge of time/date
  - Time may include an awareness of date, time of day and season.
• Oriented x 4 = knowledge of event
  - Event awareness may include knowledge of what just happened or why he’s at your Clinic.
• Obese/Skinny (Nicer Way..☺)

• Ectomorph: Lean and long, with difficulty building muscle.

• Endomorph: Big, high body fat, often pear-shaped, with a high tendency to store body fat.

• Mesomorph: Muscular and well-built, with a high metabolism and responsive muscle cells.

To Review...

• CMS has established specific requirements for documentation of both initial and subsequent office visits.

• CMS states that the following requirements MUST be included in your patient chart notes to describe the presenting complaint.

• After completing your case history with the patient, you should be able to ask yourself the questions below, and answer them with your documentation:


  • How did the condition/injury happen? Gradual or sudden? Requirement: Mechanism of onset.

  • Do my notes paint a picture of the patient's symptoms, including specific descriptive remarks that would allow a third party reader to fully understand this complaint? Requirement: Quality and character of symptoms/problems: onset, duration, intensity, frequency, location, and radiation of symptoms.

  • What causes the condition to improve or worsen? Requirement: Aggravating or relieving factors.

  • What has been tried in the past and are there any complicating factors? Requirement: Prior interventions, treatments, medications, and secondary complaints.

  • Are there any factors in the family history that relate to this condition? Requirement: Family history, if relevant.

  • What aspects of the patient's health history factor into this current condition? Requirement: Past health history (general health, prior illness, injuries, hospitalizations, medication, surgical history).

  • The symptoms should refer to the spine, muscle, bone, rib, and joint and be reported as pain, inflammation, or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder and hand problems as well as leg and foot pains and numbness. Rib and ribchrest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such.
**Initial Visit Requirements**

- **(Subjective)** Relevant History of Patient’s Condition with Detailed Description of the Present Condition. Date of Initial Treatment.
- **(Assessment)** Diagnosis.
- **(Plan)** Treatment Plan: Recommended level of care (duration and frequency of visits), Specific treatment goals, Objective measures to evaluate treatment effectiveness.

**Subsequent Visit Requirements**

- **(Subjective)** History: Review of chief complaint; Improvement or regression since last visit; System review, if relevant.
- **(Objective)** Physical Examination: Exam of the spine involved in diagnosis; Assessment of change in patient condition since last visit; Evaluation of treatment effectiveness. Showing the subluxation complex (PART).
- **(Assessment)** Documentation of Treatment Given on Day of Visit, and diagnosis.
- **(Plan)** Any Changes to the Treatment Plan.

**SOAP**

- **Subjective**
  - Review of chief complaints (is this in relationship to the initial visit or treatment for the exacerbation)
  - Changes since last visit
  - Progress toward goals
  - System review, if relevant
  - Response to last treatment?
  - Changes in symptoms?
  - Pain scale change?
  - ADL performance?

  **Railroad Medicare: Address Function!**

- **Objective**
SOAP

**Objective**
- Exam of area of the spine involved in Dx.
- Assessment of change in patient condition since last visit
- Evaluation of treatment effectiveness
- Subsequent Visits
- Physical exam findings
- Neuro/ortho tests ±
- Inspection, palpation
- Outcomes Assessment retired (30 Days – 12-15 Visits)

Evaluation of musculoskeletal/nervous system through physical examination.

In summary the Physical Exam should include
- Orthopedic and neurological tests
- Palpation findings
- Pinprick sensitivity tests
- Reflexes
- Range of motion
- Muscle strength

Cervical Spine
- ROM Using a Goniometer (Cleland et al., 2008):
  - Flexion: 40 degrees
  - Extension: 50 degrees
  - Rotation: ±5 degrees
  - Lateral Flexion: ±2 degrees

Cervical Clearing Test:
  ARQM with overpressure in all directions.
Special Tests

- Alar Ligament Test
- Bakody's Sign
- Cervical Distraction Test
- Cervical Rotation Lateral Flexion Test
- Cranio cervical Flexion Test
- Deep Neck Flexor Endurance Test
- Posterior Anterior Segmental Mobility
- Segmental Mobility
- Sharp-Purser Test
- Spurling's Maneuver
- Transverse Ligament Test
- ULNT-Median
- ULNT-Radial
- ULNT-Ulnar
- Vertebral Artery Test

Cervical Research

- Canadian C-Spine Rules:
  1. 65+ or dangerous mechanism* or paresthesias in extremities (if yes, radiographs indicated)
  2. Any low risk factor that allows safe assessment of AROM (if no, radiographs indicated)
  3. Active 45 deg of rotation bilaterally in neck (if no, radiographs indicated)

*Dangerous Mechanism: fall from elevation > 3ft, axial load to head, MVC high speed rollover/rejection, motorized recreational vehicles, bicycle collision

**Low Risk Factor: simple rear-end MVC (EXCLUDES: pushed into oncoming traffic/hit by high speed vehicle), sitting position in ED, ambulatory at anytime, delayed onset of neck pain, absence of midline C-spine tenderness

Sensitivity, Specificity, Likelihood

- Sensitivity: the true positive rate, recall, or probability of detection in some fields measures the proportion of actual positives that are correctly identified as such (e.g., the percentage of sick people who are correctly identified as having the condition).
- Specificity: the true negative rate measures the proportion of actual negatives that are correctly identified as such (e.g., the percentage of healthy people who are correctly identified as not having the condition).
- The Likelihood Ratio (LR) is the likelihood that a given test result would be expected in a patient with the target disorder compared to the likelihood that that same result would be expected in a patient without the target disorder.
- A likelihood ratio of greater than 1 indicates the test result is associated with the disease. A likelihood ratio less than 1 indicates that the result is associated with absence of the disease.

Cervical Manipulation for Neck Pain (Puentedura et al, 2012):

- Symptom duration of < 38 days
- Positive expectation that manipulation will help
- Side to side difference in cervical rotation ROM of 10 deg or greater
- Pain with PA spring testing of the middle cervical spine

3 positive: Sn .81, Sp .94, +LR 13.5
4 positive: Sn .5, Sp 1.0, +LR infinite
• Cervical Myelopathy (Cook et al, 2010):
  - Ataxic gait
  - (+) Hoffmann's Test
  - (+) Babinski Test
  - (+) Inverted Supinator Sign
  - Age > 45 years
  1 positive: Sn .94, Sp .92, +LR 1.4
  2 positive: Sn .98, Sp .99, +LR 3.3
  3 positive: Sn .99, Sp .99, +LR 30.9
  4 positive: Sn .99, Sp 1.0, +LR infinite

• Cluster for Cervical Radiculopathy Diagnosis (Wainner et al, 2003):
  - Cervical rotation < 60 degrees to the affected side
  - Distraction Test
  - Spurling's Maneuver
  - UENT-Median
  3 positive: +LR: 6.1
  4 positive: +LR: 30.3

• Mechanical Traction for Neck Pain (Raney et al, 2009):
  - Patient reported peripheralization with lower cervical spine (C4-7) mobility testing
  - Bakody's Sign
  - Age 55+
  - ULNT-A
  - Cervical Distraction Test
  3 positive: Sn .83, Sp .87, +LR 2.5
  4 positive: Sn .83, Sp 1.0, +LR 33.1

A Great Resource...
https://library.palmer.edu/c.php?q=7510278&p=5379070
Thoracic Spine

- ROM Using a Goniometer (Geelhoed et al, 2006):
  - Flexion: 20-45 degrees
  - Extension: 25-45 degrees
  - Lateral Flexion: 20-45 degrees
  - Rotation: not assessed due to difficulty differentiating from L-spine

- ROM Using a Tape Measure (Geelhoed et al, 2006):
  - Flexion: >2.7 cm
  - Extension: >2.5 cm
  - Thoracolumbar Lateral Flexion: assess distance from middle finger tip to floor (compare side-to-side)
  - Rotation: not assessed due to difficulty differentiating from L-spine

Thoracic Clearing Test: AROM in all directions with overpressure

Special Tests

- Adam's Forward Bend Test
- Passive Neck Flexion Test
- Thoracic Compression Test
- Thoracic Distraction Test
- Thoracic Foraminal Closure Test
- Thoracic Tests
- Adam's Position
- Amoss Sign
- Beevor's Sign
- Chest Expansion Test
- Rib Motion Test
- Schepelmann's Test

Cluster for Patients with Neck Pain that will Benefit from Thoracic Spine Manipulation (Gelade et al, 2007):
- Symptoms <30 days
- No symptoms distal to the shoulder
- Looking up does not aggravate symptoms
- FABQ Physical Activity Score <12
- Diminished upper thoracic spine kyphosis
- Cervical extension ROM <30 degrees

3 positive: +LR: ≤5
4 positive: +LR: ≥12
5+ positive: +LR: >12

A Great Resource...
https://library.palmer.edu/c.php?q=751027&p=573476
Lumbar Spine/Sacraliliac Joint

- **ROM of Lumbar Spine:**
  - Flexion: ~60 degrees (double inclinometer); 5-7 in (Modified-Schober)
  - Extension: ~35 degrees (double inclinometer); 1-3 in (Modified-Schober)
- **Lumbar Lateral Flexion:** 25-30 degrees (double inclinometer)
- **Thoracolumbar Lateral Flexion:** assess distance from middle finger tip to floor (compare side-to-side)
- **Rotation:** not assessed due to difficulty differentiating from T-spine

Lumbar Clearing Test:

- **Lumbar Quadrant Test**
  - **Purpose:**
    - To determine if the lumbar spine is the source of the patient's symptoms.
  - **Test Position:** Sitting.
  - **Performing the Test:**
    - The patient's arms are folded across his/her chest. The examiner places the lumbar spine in hyperextension (the examiner may choose to maintain the hyperextension by placing his/her knee against the lumbar spine), along with combined ipsilateral lateral flexion and rotation to end range. The examiner then applies an overpressure through the shoulders. A positive test is a reproduction of the patient's pain that brought him/her in to seek treatment.
  - **Diagnostic Accuracy:** Unknown.
  - **Importance of Test:**
    - As this is the lumbar clearing test, it is an extremely useful test to ascertain the source of the patient's symptoms. The combined motion of extension and ipsilateral lateral flexion and rotation decreases the intervertebral foramen to its smallest size. With overpressure, this test can detect if there is decreased space for the nerve roots or other innervated structures, with the addition of the patient's pain.

Sacraliliac Clearing Test:

- **Sacral Clearing Test**
  - **Purpose:**
    - To decide if sacroiliac joint is the source of the patient's symptoms or not.
  - **Test Position:** Prone.
  - **Performing the Test:**
    - Examiner applies a posteroanteriorly directed force to various locations of the sacrum: base, apex, and each side of the sacrum while the patient is in a prone position. The examiner palpates the innominate bone, looking for tenderness and crepitus. If any location reproduces the patient's symptoms, the examiner applies an overpressure force to the opposite side of the sacrum to test for torsional abnormalities. The examiner then applies an overpressure force to the opposite side of the sacrum to test for torsional abnormalities.
  - **Diagnostic Accuracy:** Sensitivity: .63; Specificity: .75 (Diagnosis of sacroiliac joint pain: validity of individual provocation tests and composites of tests).
  - **Importance of Test:**
    - This test performs for sacroiliac joint pain by applying pressure at various locations of the sacrum while the patient is in a prone position. The examiner looks for tenderness and crepitus, and if any location reproduces the patient's symptoms, they apply an overpressure force to the opposite side of the sacrum to test for torsional abnormalities. This test is useful in diagnosing sacroiliac joint pain.

Lumbar Tests

- **Adam's Position**
- **Kemp's Test**
- **Amoss Sign**
- **Kernig's Sign**
- **Antalgia Sign**
- **Brudzinski Sign**
- **Straight Leg Raiser**
- **Lasegue's Test**
- **Bechterew's Test**
- **Lindner's Sign**
- **Braggard's Sign**
- **Milgram's Test**
- **Crossed Straight Leg Test**
- **Minor's Sign**
- **Fajersztain's Test**
- **Nachla's Test**
- **Cox Sign**
- **Quick Test**
- **Ely's Test**
- **Sicard's Sign**
- **Femoral Nerve Traction Test**
- **Bilateral Leg Lowering Test**
- **Heel/Toe Walk Test**
Hip Tests

- Actual Leg Length Test
- Apparent Leg Length Test
- Allis Sign (aka Saleazzi's Sign)
- Anul Test
- Gaenslen's Sign
- Hip Telescoping Test
- Patrick's Test (aka Patrick-Lafebre)
- Glenn's Test
- Trendelenburg's Test

Pelvis Tests

- Anterior Innominat Test
- Belt Test
- Erichsen's Test
- Gaenslen's Test
- Goldthwait's Sign
- Hibbs Test
- Iac Compression Test
- Lewin-Gaenslen Test
- Lewin Standing Test
- Yeoman's Test

Lumbosacral Research

- Cluster for Patients Likely to Benefit from Spinal Manipulation (Childs et al, 2004):
  - Duration of current low back pain for less than or equal to 16 days
  - No symptoms below the knee
  - FABQ work subscale score 18 points or less
  - Segmental mobility testing results in finding 1 or more hypomobile segments in the lumbar spine
  - Hip internal rotation with at least one hip having at least 35 degrees of internal rotation

- 1-2 positive: -LR: 1
- 3 or 4 positive: +LR: 13.2

Lumbosacral Research

- Cluster for Patients Likely to Benefit from Lumbar Stabilization Exercise Training (Hicks et al, 2005):
  - Age <40
  - Avg Straight Leg Raise > 91 degrees
  - Positive Prone Instability Test
  - Aberrant movement present (found during lumbar ROM test). Often described as instability catch, painful arc of motion, Gow's sign, or a reversal of lumbopelvic motion

- 1 positive: -LR: 2
- 3 or 4 positive: -LR: 4.0
Lumbosacral Research

- Cluster for Pain Originating from Sacroiliac Joint (Stuber 2007):
  - Sacral Clearing Test
  - SIJ Compression Distraction Test
  - POSH Test
  - Gaenslen’s Test

1 positive: Sn 1.0, Sp .44
2 positive: Sn .93, Sp .66
3 positive: Sn .94, Sp .78
4 positive: Sn .8, Sp .81
5 positive: Sn .27, Sp .88

- Cluster for S&S Indicative of Spinal Stenosis (Cook et al, 2011):
  - Bilateral symptoms
  - Leg pain > back pain
  - Pain during walking/standing
  - Pain relieved upon sitting
  - >48 years old

1 positive: Sn .96, Sp .2, +LR 1.3, -LR .99
2 positive: Sn .68, Sp .62, +LR 1.8, -LR .52
3 positive: Sn .29, Sp .88, +LR 2.5, -LR .8
4 positive: Sn .06, Sp .98, +LR 4.6, -LR .95
5 positive: Sn .01, Sp 1.0, +LR infinite, -LR .99

Documentation

Somatic and Segmental Dysfunction
- 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.
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.

Examples of standardized pain assessment tools include, but are not limited to:

- Brief Pain Inventory (BPI)
- Faces Pain Scale (FPS)
- McGill Pain Questionnaire (MPQ)
- Multidimensional Pain Inventory (MPI)
- Neuropathic Pain Scale (NPS)
- Numeric Rating Scale (NRS)
- Oswestry Disability Index (ODI)
- Roland Morris Disability Questionnaire (RMDQ)
- Visual Analog Scale (VAS)

Important: The name of the standardized tool used to assess the patient's pain must be documented in the medical record.
Asymmetry/misalignment – sectional or segmental level
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.

- 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.
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.

To demonstrate a subluxation based on examination

Two of the Four Criteria Must be

Asymmetry

Or

Range Of Motion

P.A.R.T.

The Medical Necessity Recipe
1. Complaint
2. Explanation
3. Plan
4. Progress

*mechanism of trauma

Medical Necessity

“Services or items reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member”

Quick Check
1. Does the patient have a complaint in the area treated?
2. Are there objective findings to explain the cause of the complaint?
3. Does the record show a clear plan to correct the problem?
4. Does the record show progress towards measurable goals?
Question that we Get A lot…

- Do you monitor and document changes and assess progress in the goals on every subsequent visit?

Why outcome assessments?

- Objective measure of patients status
- Provides subjective documentation of patients condition
- Helps doctor make informed decisions
- Backed up by referenced journals (JMPT, Spine)
- Have patients complete on initial exam, and reexams or as clinically indicated at reinjury
- Test Quantify the amount of patients deconditioning present

Using OATs

- "Outcomes in clinical practice provide the mechanism by which the health care provider, the patient, the public, and the payer are able to assess the end results of health care delivery system."

Goals

- Support medical necessity by quantifying patient functional loss.
- They "objectify the subjective"
- They measure a change in health status after exposure to a health care delivery system.
For Example...

Goals

Outcome Assessment Tools

• Neck Disability Index (NDI)
• Modified Oswestry Low Back Disability Index

NDI scoring

- 0-4 points (0-8%): no disability
- 5-14 points (10-28%): mild disability
- 15-24 points (30-48%): moderate disability
- 25-34 points (50-64%): severe disability
- 35-50 points (70-100%): complete disability

i.e. 34% on NDI

Should be documented as

“moderate functional deficiency”
OATs should be administered every 30 days, or as indicated

- 10% improvement = minimum detectable change
- 30% improvement = meaningful change
- 50% improvement = substantial change

• https://www.palmer.edu/research/clinician-research-
dashboard/toolkit/collection-patient-reported-outcomes-
in-the-chiropractic-office/

**SOAP**

- Assessment
  - Current diagnosis
  - Patient response to treatment
  - Compliance
  - Changes to short and long term goals

**No Longer use..**

- Cervicalgia
- Dorsalgia
- Lumbalgia

....Due To
Sprain vs strain

- A **sprain** is a stretching or tearing of ligaments — the tough bands of fibrous tissue that connect two bones together in your joints.
  - The most common location for a *sprain* is in your ankle.
- A **strain** is a stretching or tearing of muscle or tendon.
• Pain
  • Cervicalgia
  • Dorsalgia
  • Lumbalgia

• Extremity’s

• Co-morbidities/Complicating Factors
  • Obese
  • Diabetic
  • Non Compliance
  • Age
  • High Blood Pressure

• External causes

Even if diagnosis is the same as last visit
• Document each time
• Word "same" is not acceptable
If diagnosis changes from prior visit
• Explain if it relates to past history and how
• If new diagnosis, redo P.A.R.T./S.O.A.P. notes
### Table 1

<table>
<thead>
<tr>
<th>Patient</th>
<th>Diagnosis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>145</td>
<td>Rheumatoid Arthritis</td>
<td>Chronic pain and swelling in joints, especially hands and feet.</td>
</tr>
<tr>
<td>146</td>
<td>Osteoarthritis</td>
<td>Degradation of cartilage in weight-bearing joints, leading to pain and stiffness.</td>
</tr>
<tr>
<td>147</td>
<td>Psoriatic Arthritis</td>
<td>Joint pain, swelling, and inflammation in the context of skin plaques.</td>
</tr>
<tr>
<td>148</td>
<td>Gout</td>
<td>Sudden, severe pain in joints, often the big toe, and redness.</td>
</tr>
</tbody>
</table>

**Clinical Example**

**Patient 145**

*Diagnosis:* Rheumatoid Arthritis

*Symptoms:* Chronic pain and swelling in joints, especially hands and feet.

*Medical Findings:* Inflammation in the joints, synovial fluid analysis showing increased leukocytes.

*Treatment:* NSAIDs, physical therapy, and possible biologic agents.

---

**Patient 146**

*Diagnosis:* Osteoarthritis

*Symptoms:* Degradation of cartilage in weight-bearing joints, leading to pain and stiffness.

*Medical Findings:* Radiographic evidence of joint space narrowing.

*Treatment:* Pain management, exercise therapy, and occasionally joint replacement surgery.

---

**Patient 147**

*Diagnosis:* Psoriatic Arthritis

*Symptoms:* Joint pain, swelling, and inflammation in the context of skin plaques.

*Medical Findings:* Synovial fluid analysis showing inflammatory changes.

*Treatment:* A biologic agent and methotrexate.

---

**Patient 148**

*Diagnosis:* Gout

*Symptoms:* Sudden, severe pain in joints, often the big toe, and redness.

*Medical Findings:* Elevated uric acid levels.

*Treatment:* Urate-lowering therapy and non-steroidal anti-inflammatory drugs (NSAIDs).
Example Assessment

- Minor reinjury; Lumbago with sciatica, left side with sprain of the lumbar and lumbosacral regions with associated myalgia, with associated cervicalgia dorsalgia with associated somatic and segmental dysfunction on the cervical thoracic lumbar and sacral spine, complicated by morbid obesity and Type 2 diabetes melilitus with other specified complication

- M54.42 lumbago, sciatica of the left
- S33.5XXA sprain of the ligaments of the lumbar spine
- S 20 3.3XXA sprain of the ligaments of the thoracic spine
- S33.6XXA sprain of the sacroiliac joint, initial encounter
- M54.2 Cervicalgia
- M79.18 Myalgia
- M79.12 Myalgia
- M99.01 Somatic and segmental dysfunction of the cervical spine
- M99.02 Somatic and segmental dysfunction of the thoracic spine
- M99.03 Somatic and segmental dysfunction of the lumbar spine
- M99.04 Somatic and segmental dysfunction of the sacrum spine
- E66.01 Morbid (severe) obesity
- E11.69 Type 2 diabetes mellitus with other specified complication

Based upon the patient's complaints and physical findings it is my clinical opinion that conservative physical medicine healthcare (treatment) for the current condition is medically necessary. Therefore continuation of manual manipulative therapy would be necessary.

SOAP PLAN

- Management plans include
- Frequency and duration are
- Frequency and parameters of any re-evaluations to evaluate progression of care
- Specifics of the type of care include: What is going to be done, indications, types of ESG, duration of care, rest periods, modifications to ADLs, nutrition, functional status, lengths of treatment, etc.
- Modifiers: time, settings, and intensity specifically if there are any new complaints or changes in the condition. Modified care plans with additional changes if needed or previously unsuccessful treatment plans
- Specifics of the plan of care to include: What is going to be done, modalities, types of STM, type(s) of CMT, stretches, exercises, home care, modifications to ADLs, referrals, nutritional advice, lifestyle modifications, etc.
- Modalities: - time, settings, and body part applied to
- New complaint with an established patient, report of findings given, and Informed Consent performed as necessary (new dx, modality)
- Soft tissue massage
- Type of Chiropractic manipulative therapy – flexion/distraction, diversified, drop, Activator, etc.
- Home instructions – use of ice or heat and when? How long? How much? Stretching and strengthening exercises – sets, repetitions, times per day, perform before or after ADLs, Modifiers if any
- Also, duration of treatment needs to be included if not started at time of care.
Evaluations vs. Treatments

Evaluation visit (similar to a standard visit to a medical doctor):
- Record history
- Note objective test results and observations
- Establish patient's condition/diagnosis
- Formulate a plan with quantifiable, patient-centered goals

Treatment visit (the plan is carried out):
- Update patient-centered measurable Subjective and Objective information
- Assess patient specific functional progress
- Describe procedures and where the patient is in the plan
- Review the patient's progress and the next steps of the plan

To get the whole story a reviewer would need the evaluations on either side of the treatments. This describes the entire episode of care rather than an isolated treatment.
Exam Discussion

- 10-15 Visits or Every 30 days
- Up to Clinical Decision
- Frequency and duration

• Your unique perspective makes a difference
  - If the guidelines say 2 times a week, but you feel they should be seen 4 times, then please use your individual clinical expertise.

Medicare LCD for ICD-10

Note: These are only categories. To find the complete list, contact your CMS contractor or check the "Medicare Coverage Database."
Prognosis is used to forecast the probable result of treatment for a patient’s condition.

**Short term – symptomatic**

1. Excellent
2. Good
3. Fair
4. Poor

**Long term – functional**

1. Excellent – full symptomatic and functional recovery expected within 2-4 weeks
2. Good - Symptomatic and functional recovery is expected in approximately 4-8 weeks but the patient may experience intermittent mild pain and some restriction of motion
3. Fair - The patient can expect to have a reduction of their symptom although some persistent pain and stiffness from the injury is expected and may require ongoing rehabilitation.
4. Poor - The nature of the patient’s injury and preexisting conditions being introduced the likelihood of full recovery. It is expected the patient will continue to experience intermittent to occasional paresthesias along with occasional to frequent pain and stiffness, necessitating palliative care.
5. Guarded - The patient’s condition is not expected to improve in the near future. They may expect to have continued muscle weakness and sensory deficit. Palliative and/or supportive care will be warranted for symptomatic relief and some improvement of function.
6. Unstable - Patient has not responded to the treatment trial and demonstrates evidence of deterioration. The likelihood of recovery with conservative care does not appear promising at this time. Surgical consult would be advisable.
Let’s Get Down to Business Series

DOCUMENTING TREATMENT PLANS

Thank you!

WCA

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