Best Practices in Clinical Documentation

(6 hours - SC BOE Approved)

Seminar sponsored by Health Network Solutions (HNS)

Dr. Kevin Sharp

Our responsibility

“There has never been a time in the history of our profession with a greater opportunity to deliver conservative health care. The over-riding question is “are we prepared to embrace the opportunities?” Can we create an environment that promotes greater penetration into the health care market place? Will we create an environment that allows us to practice to the full complement of our training and competencies? Can we create an environment that reimburses us at the level of all other physician-level providers?”

Dr. Tony Hamm,

ACA President

Program Objectives

Today we are going to review “best practices” for clinical record keeping. These best practices:

- Promote quality health care;
- Improve treatment outcomes;
- Help protect you in the event of a post-payment payor audit!

Documentation Authorities

Documentation Authorities

Various authorities on documentation

- American Chiropractic Association - Solid national standards of documentation
- CMS – additional national standards
- Payor and Network Policies

The “Best Practices” we will be reviewing today are consistent with industry standards and developed to be appropriate for ALL payors, including Medicare)

Getting Started

Clinical Records
Quality Standards

The Healthcare Record

The healthcare record is a **legal document**, and has many roles, in addition to those involved in caring for a patient where documentation of the patient's health history, health status (sickness and wellness), observations, measurements, and prognosis are recorded.

This documentation allows the record to serve as the legal record substantiating healthcare services provided to the patient (aka: Medical Necessity). It also serves as a method of communication among healthcare providers caring for a patient and provides supporting documentation for reimbursement of services provided to a patient.

The Healthcare Record

The roles of the legal healthcare record are to:

Support the decisions made in a patient's care

Support the revenue sought from third-party payors.

Document the services provided as legal testimony regarding the patient's illness or injury, response to treatment and care giver decisions.

Important Note About Electronic Clinical Records

The use of electronic health records (EHR)and electronic documentation software programs is highly recommended.

Best practice:

If electronic records are utilized, there must be appropriate back-up and recovery procedures in place.

Recovery procedures should be tested at least annually to assure recovery is possible within a reasonable period of time.

Most Important Core Standard to PROTECT YOUR PRACTICE

Best practices:

- Ensure that ALL services provided and billed to a payor are **medically necessary**, consistent with the patient's chief complaint/clinical findings, diagnoses and treatment plan; are properly documented in the patient's healthcare record and properly reported using the most appropriate CPT, HCPCS and ICD code(s).

- All services provided and billed should be consistent with payor policies, the policies of applicable state licensing boards as well as state and federal laws.

General Documentation Requirements

Documentation/Compliance

Initial Visit
Diagnosis
Informed Consent
Medical Necessity
Chief Complaint
Treatment Plans
Radiology
Subsequent Visits

General Documentation Requirements to meet industry standards

Best practices:
General Documentation Requirements to Protect Your Practice

- A. All healthcare records should be *accurate, complete and legible to someone other than the author.*
- B. The patient healthcare record must include documentation for all services performed in the office as well as all communication and correspondence from other sources regarding the patient.
- C. All services and procedures reported must be represented by the most appropriate CPT, HCPCS and ICD codes.
- D. The patient's healthcare record must include documentation to support any modifier reported.
- E. ALL covered services provided and billed must be properly reported, properly documented in the healthcare record, must be medically necessary and consistent with the patient's chief complaint, clinical findings, diagnoses and treatment plan.
- F. For care billed to payors, services provided and billed should be delivered in the most effective and cost-efficient manner.

Best practices:
General Documentation Requirements to Protect Your Practice

- G. The healthcare record must include written evidence that the provider obtained informed consent from each patient prior to initiating treatment.

- H. Each page of the healthcare record must include the name of the patient and the signature (or electronic equivalent) of the rendering provider, including the professional designation “DC”.

- I. Documentation in the healthcare record must reflect that all services provided and billed are consistent with all contracted payor policies, the policies of applicable state licensing boards as well as state and federal laws.

Best practices:
General Documentation Requirements to Protect Your Practice

- J. Entries to the healthcare record should be made during or closely following the patient encounter.
- K. Entries should be added chronologically.
- L. No entries should be erased, deleted, or “whited out”. Corrections or changes should be made by marking a single line through the original entry. Both the entry that is marked through AND the corrected entry should be dated and initialed.
- M. Copies of any written or verbal communication and/or correspondence should be maintained in the patient’s healthcare record and must be signed by the treating physician. This includes, but is not limited to, consultations, test results, reports, letters, consent forms, pertinent notes from phone conversations with patients, etc.

Best practices:
General Documentation Requirements to Protect Your Practice

- N. Results of all diagnostic reports must be signed and dated by the reviewing/rendering provider and must be included in the healthcare record.

- O. Documentation must include appropriate treatment plans for each phase of care pursued.

- P The patient's healthcare record must include S.O.A.P. notes and review of ADLs.

- Q. If abbreviations are utilized, only standard abbreviations common to all healthcare providers should be used. Abbreviations in the healthcare record should be legible. The abbreviation legend should be maintained in the provider's office.

Best Practice
Informed Consent

Best Practice – Informed Consent

- We are legally and ethically obligated to obtain informed consent from our patients **prior to initiating treatment**.
- Consent cannot be considered “informed” unless, at a minimum, the physician orally explains the risks associated with the proposed course of treatment, answers any questions the patient may have, and obtains the patient’s permission to treat.
- The discussion should include the risks and benefits of treatment, alternatives to treatment, and the discussion should include a review of likely outcomes, if treatment is withheld or refused.
- If the patient is a minor or an incompetent adult, the informed consent discussion must include the patient’s parent or legal guardian.

Best Practices – Informed Consent

During ongoing treatment there may be a “new condition” or “added condition”.

Providers should obtain new informed consent **when presented with a new condition that was not addressed when previous informed consent was obtained**. Written evidence in the clinical record that the provider obtained the consent from each patient prior to initiating treatment should **ALWAYS** be included in the clinical record.

(i.e. - lumbar manipulation conditions have a different group of risks of injury then that of cervical manipulation and a 70 year old may have different risk factors than a twenty year , or you are treating a low back condition and the patient develops a cervical complaint, etc.)

Best Practice – Informed Consent

While a form cannot replace the required face-to-face discussion between physician and patient, *written evidence that the provider obtained informed consent from each patient prior to initiating treatment should **ALWAYS** be included in the clinical record.*

Chief Complaint

Chief Complaint

- Chief Complaint is a concise statement describing the symptoms, problems, conditions or other factors that are the reason for the encounter and is usually stated in the patient's own words.

Best Practices:

- A. Details of complaint must be clearly documented in the healthcare record.
- B. Timing and intensity of complaints must be clearly documented.
- C. Causation of the complaint must be documented including accident, injury, and etiology.
- D. Services billed to the payor should be consistent with the patient's chief complaint/clinical findings.

Initial Visit/Examination

Best Practices: Initial Visit/Examination

- The patient's healthcare record should include **patient and demographic information, date history taken, past history, family history, and social history** (occupation, recreational interests, and hobbies).
- The patient's healthcare record should include **chief complaint(s).**
- The patient's healthcare record should include **onset, duration, frequency, location and radiation of symptoms**.
- The patient's healthcare record should **include aggravating or relieving factors**.

More Best Practices:

- The patient's healthcare record should include **causation, accident, injury, or other etiology.**
- The patient's healthcare record should **reflect any health risk factors** that have been identified.
- The patient's healthcare record should indicate whether diagnostic tests or patient histories revealed any **contraindications warranting x-rays prior to treatment.**

More Best Practices:

- The examination should include a consultation to ascertain history and such relevant orthopedic, neurological and chiropractic tests as are necessary to establish the extent and severity of the injury or condition.

- (Standardized outcome assessment (OA) tools should be used during the initial examination to establish a baseline. More about OAs later…)

- The patient's healthcare record should include ALL clinical or examination findings, as well as the results of the tests. (objective and subjective and must include vitals) (...Medical necessity requires documented *objective clinical findings*...)

More Best Practices:

Documented,* objective *clinical exam findings must substantiate the necessity of services billed.

- Clinical exam findings must **include specific segments and location of subluxations.**

- There are <u>two ways</u> in which the level of subluxation may be specified:

  1. The exact bones may be listed, for example: C5, C6, etc.

  2. The area may be reported *if it implies only certain bones* such as: Occipital-atlantal (occiput and C1 (atlas)), lumbo-sacral (L5 and sacrum), sacro-iliac (sacrum and ilium).

Best Practices:

To report CMT to payors, subluxations must be demonstrated, and must be demonstrated by one of two methods: x-ray or physical examination.

Physical Exam

To demonstrate a subluxation based on a physical examination, two of the four criteria below are required, **one of which MUST be asymmetry/misalignment or range of motion abnormality.**

1. Pain/tenderness evaluated in terms of location, quality and intensity

2. Asymmetry/misalignment identified on a sectional or segmental level

3. Range of motion abnormalities (changes in active, passive, and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility)

4. Tissue changes in the characteristics of contiguous or associated soft tissues; including skin, fascia, muscle, and ligament

Best Practice

X-ray

To demonstrate a subluxation by x-ray, the x-ray must have been taken at a time reasonably proximate to the initiation of treatment.

- An x-ray is considered reasonably proximate if it was taken:

  1. No more than 12 months prior to the initiation of a course of treatment or;

  2. No more than 3 months following the initiation of a course of treatment.

Best Practice: Vitals

- Vital signs should be obtained as part of *every* examination for which an evaluation/management (E/M) code is billed, and results must be documented in the health care record. At a minimum, obtain and document the following:

- Weight
- Pulse
- Blood Pressure

- Other vitals may be appropriate but are left to the discretion of the physician and should be appropriate based on the level of examination performed.

- When a new patient presents requesting only maintenance care, vitals should be taken as part of the initial evaluation. The physician may exercise clinical judgment as to the frequency of repeating them.

More Best Practices: Outcome Assessments

Best practices include the use of Outcome Assessment Tools on the initial examination, to establish a baseline

(and on ALL subsequent exams to determine the effectiveness of treatment provided and to measure the patient's progress towards treatment goals).

(More on OA later…)

More Best Practices:

The clinical record must include written evidence of examination for presenting symptoms, including examination of area involved in chief complaint.

The examination should include appropriate **orthopedic, neurological and chiropractic tests/outcome assessments** as are necessary to:

- **To establish the extent and severity of the injury or condition; and**
- **To allow the physician to establish *objective*, *measurable* and *reasonable* treatment goals.**

More Best Practices:

For services provided and billed to payors, clinical examination findings must *objectively* substantiate the medical necessity of the services provided and must be consistent with the patient's chief complaint, diagnoses and treatment plan.

The clinical record must also include sufficient documentation to substantiate the specific level of E/M code reported.

The examination and all clinical findings must be properly documented in the patient’s healthcare record.

Best Practices – Assessment

Best Practices – Assessment

The assessment should include **obstacles to recovery and strategies to overcome**, if applicable.

The assessment should also include **diagnoses** and **prognosis**.

(Treatment goals may be included in the Assessment if they are not included in the Treatment Plan.) More on treatment plans to come…

Diagnostic Impression

Best Practices – Diagnoses

The clinical record must include ALL diagnostic impressions.

Diagnoses must be:

- Consistent with the patient's chief complaint and objective clinical findings.
- Must clearly support ALL of the treatment outlined in the treatment plan.

All services/DME provided in the clinical record must be supported by an appropriate diagnosis which is documented in the health care record.

Any changes in diagnoses must be documented in the clinical record.

(Many services we see in audits are not supported by a diagnosis, and/or the diagnosis is not consistent with exam findings.

Best Practices – Diagnoses

If a diagnosis is in the record,
it must be supported by *documented clinical exam findings* and should be consistent with the patient's chief complaint.

Best Practices –Diagnostic Impression

- All diagnoses *reported on the insurance claim* must be documented in the healthcare record and must be reasonable and must be supported by documented chief complaint/clinical findings, diagnostic tests and other available information.

- The patient's healthcare record must reflect ALL diagnoses/clinical impressions.

- Any **changes** in diagnoses must be documented in the patient's healthcare record.

- The provider must utilize the ICD codes that appropriately reflect the findings of the patient visit and supports the necessity of care.

Best Practices

The Treatment Plan

Best Practices – Treatment Plans

For each episode of care, a properly prepared and properly documented treatment plan for the improvement of the patient's condition must be included in the patient's healthcare record.

Best Practices – Treatment Plans

The patient's treatment plan must include,
at a minimum, these 5 things:

1. **Treatment goals** to improve a functional loss experienced by the patient. (Could be included under Assessment notes)

2. Anticipated **number and frequency of visits**. (Should not exceed 12 visits/4 weeks, as at that time you will evaluate tx effectiveness, patient progress towards tx goals and medical necessity of additional care).(More about re-exams coming up!)

3. **CMT** recommended, including specific areas to be manipulated with reference to frequency and duration;

4. All **planned therapies/modalities** recommended, **the rationale for each**, including areas of application, frequency, duration, and if time based therapy is planned, the length of time the service will be provided (i.e. 15 minutes).

5. **ALL other treatment recommended by the provider**, including work disability, DME and any home instructions.

More Best Practices – Treatment Plans

ALL subsequent visits
should reference the patient's progress *as it relates to treatment goals.*

- Changes or alterations to the course of treatment that differ from the initial treatment plan must be clearly documented and must include rationales.
- If there is a change to the working diagnosis or diagnoses, the provider must modify the treatment plan/tx goals and/or prepare a new treatment plan with new tx goals).

More Best Practices – Treatment Plans

ALL covered services
included in the treatment plan,
must be consistent with the chief complaint, clinical findings, and diagnoses.

Establishing Tx Goals and Outcome Assessments

Best Practices – Treatment Goals

- The goal of treatment should be to **improve a functional loss** experienced by the patient.

- Treatment goals must be **reasonable, objective, and measurable**.

Best Practices – Treatment Goals

Should be to improve a functional deficit related to the patient's *present* condition.

Should address specific ADLs the patient is unable to perform!

"*Reasonable*"

Goals Must be Reasonable

Must consider chronic conditions as well as certain structural conditions. (What was the patient's pre-injury status????)

Let's say we have a patient with low back pain, with limited range of motion and severe spondylosis.

For this patient,
what would be a "reasonable" goal?

Goals must be Objective & Measurable

Objective

Fact-based; observable.

Measurable

Goals must be measurable so that we can determine:

- Patient progress / effectiveness of care
- Appropriateness of continued care
- When MMI has been reached.

Outcome assessments are necessary to establish measurable goals.

Best Practices – Outcome Assessments

The use of valid and reliable outcome assessment tools in the management of neuromusculoskeletal disorders is considered a “best practice”.

In order to develop appropriate treatment goals**,** and to make an objective, valid and reliable determination of meaningful progress towards treatment goals, and to determine when MMI has been reached, it is essential that relevant standardized outcome assessments (OA) tools are utilized during the initial (and ALL subsequent examinations and that results of the OAs are compared to previous OA results.)

Outcome assessments:

- Help establish reasonable, objective and measurable goals
- Help improve treatment outcomes
- Support clinical decision making

The case for OA…

Best Practice:

Initial Exam:
Outcome assessments tools should be used during the initial examination, to establish a baseline, and are **essential for establishing treatment goals which are measurable**.

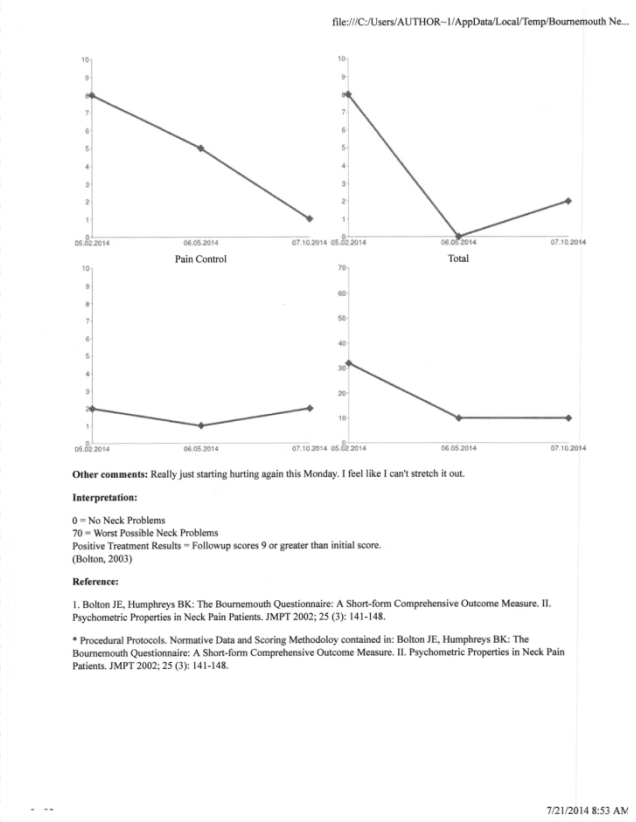
Re-exam:
Outcome Assessment Tools should be utilized on *each subsequent re-exam*, to *determine the effectiveness of treatment and to measure patient progress toward treatment goals, and to determine when MMI has been reached*.
(More about OAs and re-exams later…)

Outcome Assessment Forms

- Bournemouth Back Questionnaire
- Bournemouth Neck Questionnaire
- Oswestry Low Back Pain Disability Form
- Roland Morris Questionnaire
- Neck Disability Index Questionnaire
- ADL Form

Any generally accepted, standardized outcome assessment tools may be used.

Outcome Assessments scoring…



file:///C:/Users/AUTHOR~1/AppData/Local/Temp/Bournemouth Ne...

Pain Control

Total

Other comments: Really just starting hurting again this Monday. I feel like I can't stretch it out.

Interpretation:

0 = No Neck Problems
70 = Worst Possible Neck Problems
Positive Treatment Results = Followup scores 9 or greater than initial score.
(Bolton, 2003)

Reference:

1. Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. JMPT 2002; 25 (3): 141-148.

* Procedural Protocols. Normative Data and Scoring Methodoloy contained in: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. JMPT 2002; 25 (3): 141-148.

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- Adds value to your treatment plan and objectives.
- Helps establish medical necessity.
- Supports clinical decision making.

Examples of Treatment Plans

Chiropractic Treatment Plan

Patient Name _____ Attending Doctor _____, D.C.

Chief Complaint _____ Date _____

Diagnosis: (Please circle or insert the ICD-9 codes related to this treatment plan)

Cervical Dx:	739.1	723.1	_____	_____	_____	_____
Thoracic Dx:	739.2	724.1	_____	_____	_____	_____
Lumbar Dx:	739.3	724.2	_____	_____	_____	_____
Pelvis Dx:	739.5	_____	_____	_____	_____	_____
Sacral Dx:	739.4	_____	_____	_____	_____	_____
ExtraSpinal Dx: _____		_____	_____	_____	_____	_____

Chiropractic Manipulative Therapy (CMT) - (Must be supported by Chief Complaint, Clinical Exam Findings and Diagnosis)

☐	98940	Cervical ___	Thoracic ___	Lumbar ___	Sacral ___	Pelvic ___	
☐	98941	Cervical ___	Thoracic ___	Lumbar ___	Sacral ___	Pelvic ___	
☐	98942	Cervical ___	Thoracic ___	Lumbar ___	Sacral ___	Pelvic ___	
☐	98943	Shoulder___	Elbow ___	Wrist ___	Knee ___	Ankle ___	Foot ___

Specific Modalities to be Used in Treatment – (Must relate to documented diagnosis)

Therapy Type	Cervical	Thoracic	Lumbar	Sacrum	Pelvis	Extraspinal
97014 - Elect. Stim.						
97012 - Mechanical Traction						
97010 - Hot Packs						
97010 - Ice Packs						
97140 - Manual Therapy						
97124 - Massage						
97110 - Thera. Exercises						
97035 - Ultrasound						
If any non-covered services are recommended, 1st obtain a signed waiver from the patient.						

Attending Doctor's Signature _____

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Patient Name _____ **Date** _____

Specific Treatment Goals -(goals must be objective and measurable)

Improve Patient's Functional Deficits in ADL's _____
Reduce Swelling _____
Reduce Spasms _____
Increase Spinal / Joint ROM _____
Reduce Pain _____
Increase Spinal / Joint Strength _____
Reduce level of impairment due to current symptoms (VAS) _____
Other _____

Treatment Period and Frequency of Visits
Estimated treatment plan beginning _____/_____/_____ to _____/_____/_____
Estimated # of Visits per week _____
Estimated # of Weeks at that Frequency _____
Date of Re-evaluation (*required approximately every 10-12 treatments or 4 weeks*) _____/_____/_____

Patient Disability

From _____/_____/_____ to _____/_____/_____

Patient Restrictions

☐ Sitting	☐ Bending	☐ Pushing/ Pulling
☐ Reaching	☐ Twisting	☐ Walking
☐ Standing	☐ Lifting – Avoid lifting over _____ pounds	

Home Care Recommendations

☐ Ice ……Apply for _____ minutes every _____ hours
☐ Moist Heat……Apply for _____ minutes every _____ hours
☐ Cervical Pillow
☐ Cervical Collar……..Use only when in a car _____ Wear constantly_____
☐ Lumbar Support……Use only during activity _____ Wear constantly_____
☐ Exercises: Cervical ____ Thoracic ____ Lumbar ____ Protocol Used _____
☐ Nutritional Supplements _____
☐ Orthotics
☐ TENS
☐ Other _____

Recommendations – (If patient fails to meet treatment goals during this plan period)

☐ Chiropractor - Specialist
☐ Family Physician
☐ Neurologist
☐ Neurosurgeon
☐

Attending Doctor's Signature _____ **Date** _____

Patient Name _____ **Date** _____

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☐ Cervical Pillow
☐ Cervical Collar……...Use only when in a car _____ Wear constantly_____
☐ Lumbar Support……Use only during activity _____ Wear constantly_____
☐ Exercises: Cervical ____ Thoracic ____ Lumbar ____ Protocol Used _____
☐ Nutritional Supplements _____
☐ Orthotics
☐ TENS
☐ Other _____

Recommendations – (If patient fails to meet treatment goals during this plan period)
☐ Chiropractor - Specialist
☐ Family Physician
☐ Neurologist
☐ Neurosurgeon
☐

Attending Doctor's Signature _____ **Date** _____

Patient Name _____ **Date** _____

Specific Treatment Goals -(goals must be objective and measurable)

Improve Patient's Functional Deficits in ADL's _____
Reduce Swelling _____
Reduce Spasms _____
Increase Spinal / Joint ROM _____
Reduce Pain _____
Increase Spinal / Joint Strength _____
Reduce level of impairment due to current symptoms (VAS) _____
Other _____

Treatment Period and Frequency of Visits
Estimated treatment plan beginning _____/_____/_____ to _____/_____/_____
Estimated # of Visits per week _____
Estimated # of Weeks at that Frequency _____
Date of Re-evaluation (*required approximately every 10-12 treatments or 4 weeks*) _____/_____/_____

Patient Disability

From _____/_____/_____ to _____/_____/_____

Patient Restrictions

☐ Sitting	☐ Bending	☐ Pushing/ Pulling
☐ Reaching	☐ Twisting	☐ Walking
☐ Standing	☐ Lifting – Avoid lifting over _____ pounds	

Home Care Recommendations
☐ Ice ……Apply for _____ minutes every _____ hours
☐ Moist Heat……Apply for _____ minutes every _____ hours
☐ Cervical Pillow
☐ Cervical Collar……..Use only when in a car _____ Wear constantly_____
☐ Lumbar Support……Use only during activity _____ Wear constantly_____
☐ Exercises: Cervical ____ Thoracic ____ Lumbar ____ Protocol Used _____
☐ Nutritional Supplements _____
☐ Orthotics
☐ TENS
☐ Other _____

Recommendations – (If patient fails to meet treatment goals during this plan period)
☐ Chiropractor - Specialist
☐ Family Physician
☐ Neurologist
☐ Neurosurgeon
☐

Attending Doctor's Signature _____ **Date** _____

Patient Name _____ **Date** _____

Specific Treatment Goals -(goals must be objective and measurable)

Improve Patient's Functional Deficits in ADL's _____
Reduce Swelling _____
Reduce Spasms _____
Increase Spinal / Joint ROM _____
Reduce Pain _____
Increase Spinal / Joint Strength _____
Reduce level of impairment due to current symptoms (VAS) _____
Other _____

Treatment Period and Frequency of Visits
Estimated treatment plan beginning _____/_____/_____ to _____/_____/_____
Estimated # of Visits per week _____
Estimated # of Weeks at that Frequency _____
Date of Re-evaluation (*required approximately every 10-12 treatments or 4 weeks*) _____/_____/_____

Patient Disability

From _____/_____/_____ to _____/_____/_____

Patient Restrictions

☐ Sitting	☐ Bending	☐ Pushing/ Pulling
☐ Reaching	☐ Twisting	☐ Walking
☐ Standing	☐ Lifting – Avoid lifting over _____ pounds	

Home Care Recommendations

☐ Ice ……..Apply for _____ minutes every _____ hours
☐ Moist Heat……..Apply for _____ minutes every _____ hours
☐ Cervical Pillow
☐ Cervical Collar……...Use only when in a car _____ Wear constantly_____
☐ Lumbar Support……Use only during activity _____ Wear constantly_____
☐ Exercises: Cervical ____ Thoracic ____ Lumbar ____ Protocol Used _____
☐ Nutritional Supplements _____
☐ Orthotics
☐ TENS
☐ Other _____

Recommendations – (If patient fails to meet treatment goals during this plan period)
☐ Chiropractor - Specialist
☐ Family Physician
☐ Neurologist
☐ Neurosurgeon
☐

Attending Doctor's Signature _____ **Date** _____

Patient Name _____ Date _____

Orthopedic Surgeon
- ☐ Spinal Specialist
- ☐ Rheumatologist
- ☐ Radiologist
- ☐ Pain Management Specialist
- ☐ MRI
- ☐ CT Scan
- ☐ Nerve Conduction Velocity Test
- ☐ Other _____

(If patient successfully meets treatment goals at completion of this plan period)
- ☐ Supportive / Maintenance Chiropractic Care

Attending Doctor's Signature _____ Date _____

Coding for the Initial Visit/Examination

Codes for the Initial Visit/Examination
The Basics!

- You must use the correct level of E/M code to report your examination.

- **Report of findings are included** in your E/M visit and cannot be billed using an additional E/M code, even if done on a different day.

99201 Brief Initial Exam

- **Requires these 3 key components**
  - Problem focused history
  - Problem focused examination
  - Straight forward medical decision making
- **Counseling and/or coordination of care**
  - Counseling is a discussion with a patient or family member concerning one of the following areas:
    - Diagnostic test results, impression
    - Prognosis
- Risks and benefits of treatment options
- Instructions for treatment options
- Importance of compliance with chosen option
- Risk factors
- Education
- **Usually**, the presenting problems are self limited or minor. Providers typically spend **10 minutes** face-to-face with the patient or family.

99202 Limited Exam

- **Requires these 3 key components**
  - Expanded problem focused history
  - Expanded problem focused examination
  - Straight forward medical decision making
- **Counseling and/or coordination of care**
- **Counseling is a discussion with a patient or family member concerning one of the following areas:**
  - Diagnostic test results, impression
  - Prognosis
  - Risks and benefits of treatment options
  - Instructions for treatment options
  - Importance of compliance with chosen option
  - Risk factors
  - Education

… more on 99202

- If the visit consists predominantly (more than 50%) of counseling or coordination of care, ***direct face-to-face time is the key to qualifying for a particular level of E/M*** service.

- Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient or family needs. Usually, the presenting problems are of low to moderate severity. Providers **typically** spend **20 minutes** face-to-face with the patient or family.

99203 Intermediate Exam

- **Requires these 3 key components**
  - Detailed history
  - Detailed examination
  - Medical decision making of low complexity

- **Counseling and/or coordination of care**

Counseling is a discussion with a patient or family member concerning one of the following areas:

- Diagnostic test results, impression
- Prognosis
- Risks and benefits of treatment options
- Instructions for treatment options
- Importance of compliance with chosen option
- Risk factors
- Education

…more on 99203

- If the visit consists predominantly (more than 50%) of counseling or coordination of care, ***direct face-to-face time is the key to qualifying for a particular level of E/M*** service.
- Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient or family needs. Usually, the presenting problems are of moderate severity. Providers **typically** spend **30 minutes** face-to-face with the patient or family.

99204 & 99205

- These are very “high value” exam codes and are **very infrequently** used in a chiropractic office setting. As such, they are high audit ‘trigger’ codes!

- If you do use them, spend particular time to make sure that full and thorough documentation is completed. Face to face time is estimated to be between **45-60 minutes** respectively.

E/M Consultation Codes

E/M Consultation Codes

- **<u>E/M Services - Consultations</u>**

- Consultation E/M codes should ONLY be billed when *another physician, insurer, employer, or other appropriate source has requested your opinion or advice.*

- A consultation initiated by a patient, and/or family member and not requested by a physician or other appropriate source should not be reported using an E/M Consultation code.

- Coding Note: **"Report of Findings" visits do not meet the requirements of an E/M Consultation** so providers should not report their standard "Report of Findings" visits using an E/M CPT code.

E/M Consultation Codes

- *When another physician, insurer, employer, or other appropriate source has requested your opinion or advice, it is appropriate to report an E/M Consultation code. If such a consultation has been requested:*

- The verbal or written request must be clearly documented in the patient's healthcare record including the name of the provider or organization requesting the advice or opinion, and the date it was received.

- The provider's written report to the requesting physician or appropriate organization, including his opinion, advice and/or any services ordered or performed, must be clearly documented in the patient's healthcare record. A copy of this report must be maintained in the patient's healthcare record.

- Consultation codes are: 99241-99245

Best Practices- Re-examinations

Best Practices – Re-examinations…

When?

To evaluate treatment effectiveness and patient's progress toward treatment goals, *and to determine the appropriateness of additional care*, re-examinations should be performed approximately every 4 weeks or every 12 visits, (whichever comes first).

Best Practices – Re-examinations…

The clinical record will:

- Include documentation of all re-examinations performed.
- Indicate any tests performed and the results of those tests.
- ALL clinical examination findings **(objective and subjective).**
- Include sufficient documentation to substantiate the specific level of E/M code reported.

Vitals

should be obtained during each re-exam and results must be documented in the healthcare record.

Value and Importance of Re-examinations…

Re-examinations, <u>if properly done and properly documented</u>:

- Provide objective evidence of patient's progress toward treatment goals.
- Determine the effectiveness of treatment to date and whether treatment should be continued, modified, or discontinued.
- Help to determine the appropriateness of additional care that can be billed to the payor.
- Determine when MMI has been reached.

The case for OAs during Re-exams

Best Practice:

Outcome assessments tools should be used during the initial examination, to establish a baseline (and are **essential for establishing treatment goals which are <u>measurable</u>**.)

<u>Re-exam:</u>

Outcome Assessment Tools should be utilized on *each subsequent re-exam* and results compared to results of previous OAs.

Best Practices –

Outcome Assessments:

- Should be used to **objectively measure progress toward treatment goals**.
- Should be used to demonstrate effectiveness of treatment.
- Should be used to determine the **appropriateness and medical necessity of continued care.**
- Should be used to help determine **when MMI has been reached**

Without OA…

Without the use of outcome assessment tools during the initial examination and at all subsequent examinations, how do you objectively measure patient progress toward treatment goals?

If you aren't measuring and comparing patient progress toward treatment goals, you will not be able to objectively demonstrate treatment effectiveness!

If you aren't measuring patient progress toward treatment goals, you will not be able to objectively determine when MMI has been reached!

Example of scored OA

SHARP CHIROPRACTIC

Functional Ability Score©

Sharp Chiropractic PC

First Name : [redacted]
Last Name : [redacted]
Date of birth : 12.11.1952
Completed on : 06.22.2015 at 06:28pm

Assessment Tool: Functional Ability Score

Introduction: The Functional Ability Score is an instrument specifically designed to quantitatively measure the subjective sense of pain and function of the musculoskeletal system in a clinical environment. In particular, it evaluates the patient's subjective report of his ability to perform the most common daily functions. The Functional Ability Score emphasizes function while concurrently measuring the patient's opinion and self-rating of disability.

The 10 categories of the Functional Ability Score used to profile the amount of dysfunction and pain includes:

1. Pain Free Function
2. Sleeping
3. Sitting
4. Standing
5. Walking
6. Kneeling
7. Squating and Bending
8. Climbing Stairs
9. Reach Forward and Push/Pull
10. Lift and Carry

The overall Functional Ability Score is based upon a 0 to 10 possible score for each of the ten categories, which provides a total possible score of 100. 0 represents the worst possible score in each category and 10 the best. The final score is a summation of all 10 categories and expressed as a percentage of 100. 100% represents the highest score possible.

Patient Results: The Outcomes Assessment Summary lists the current Functional Ability Score compared to the best possible score of 100.

Treatment Goals: Follow up Functional Ability Score to score more than the initial score and optimally score as close to 100%.

Current Treatment Results: The Outcomes Assessment Summary demonstrates the current score compared to the previous score. A positive CURRENT CHANGE number on the Outcomes Assessment summary reflects health IMPROVEMENT from the previous assessment whereas a negative number reflects health WORSENING.

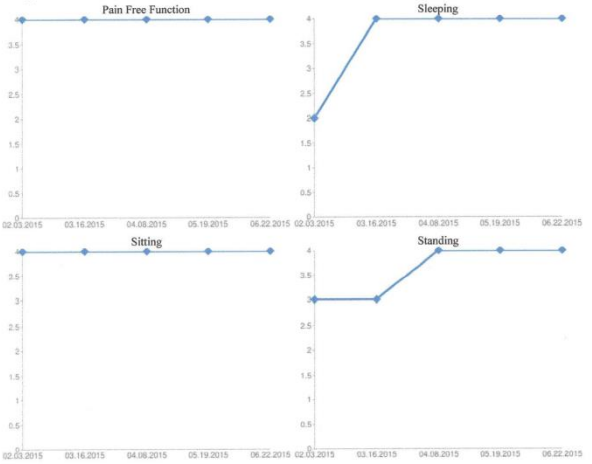
Overall Treatment Results: The Outcomes Assessment Summary demonstrates the current score compared to the initial score. A positive OVERALL CHANGE number on the Outcomes Assessment summary reflects health IMPROVEMENT from the previous assessment whereas a negative number reflects health WORSENING.

Functional Ability Score©

Sharp Chiropractic PC

First Name : [redacted]
Last Name : [redacted]
Date of birth : 12.11.1952
Completed on : 06.22.2015 at 06:28pm

	Pain Free Function	Sleeping	Sitting	Standing	Walking	Kneeling	Squating and Bending	Climbing Stairs	Reach Forward and Push/Pull	Lift and Carry	Total
02.03.2015	4	2	4	3	5	0	1	7	0	1	27
03.16.2015	6	4	4	3	9	2	2	10	2	1	43
04.08.2015	8	5	6	5	8	0	2	7	3	1	45
05.19.2015	7	5	9	6	10	10	9	10	2	3	71
06.22.2015	4	4	8	4	7	2	1	6	7	1	44
Current Change	-3	-1	-1	-2	-3	-8	-8	-4	5	-2	-27
Overall Change	0	2	4	1	2	2	0	-1	7	0	17



Functional Ability Score

Pain Disability Questionnaire

SHARP CHIROPRACTIC

Pain Disability Questionnaire©

Sharp Chiropractic PC

First Name : [redacted]
Last Name : [redacted]
Date of birth : 12.11.1952
Completed on : 06.22.2015 at 09:30am

Assessment Tool: The Pain Disability Questionnaire

Introduction: The Pain Disability Questionnaire (PDQ) is a comprehensive psychometric evaluation of functional status (1). The focus is primarily on disability and function. This instrument is designed for the full array of chronic disabling musculoskeletal disorders, rather than low back pain alone. The psychometric properties of the PDQ are excellent, demonstrating strong reliability, responsiveness, and validity.

The PDQ is made up of two factors: a Functional Status Component comprising a maximum of a 90 score and a Psychosocial Component comprising a maximum of a 60 score. This yields a total functional disability score ranging from 0 to 150.

Patient Results: The Outcomes Assessment Summary lists the current total PDQ "functional" score compared to 90, "psychosocial" score compared to 60 and "total" score compared to the worst possible score of 150.

Treatment Goals: Follow up PDQ scores less than initial with the optimal total score of 0/150.

Current Treatment Results: The Outcomes Assessment Summary demonstrates the current score compared to the previous score. A **positive** CURRENT CHANGE number on the Outcomes Assessments Summary reflects health IMPROVEMENT from the previous assessment whereas a **negative** number reflects health WORSENING. A positive CURRENT CHANGE number greater than 28 reflects a positive treatment result (1).

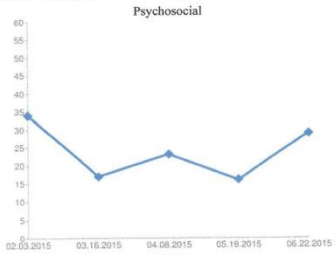
Overall Treatment Results: The Outcomes Assessment Summary demonstrates the current score compared to the initial score. A **positive** OVERALL CHANGE number on the Outcomes Assessments Summary reflects health IMPROVEMENT from the previous assessment whereas a **negative** number reflects health WORSENING. A positive OVERALL CHANGE number greater than 28 reflects a positive treatment result (1).

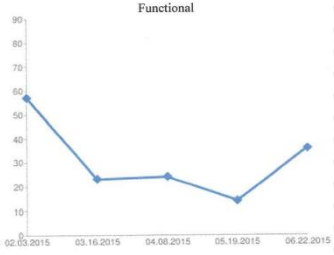
Pain Disability Questionnaire©

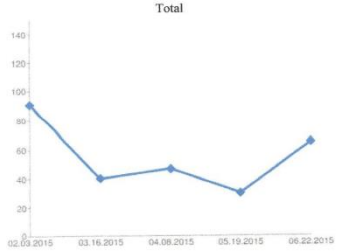
Sharp Chiropractic PC

First Name : [redacted]
Last Name : [redacted]
Date of birth : 12.11.1952
Completed on : 06.22.2015 at 09:30am

	Psychosocial	Functional	Total
02.03.2015	34/60	57/90	91/150
03.16.2015	17/60	23/90	40/150
04.08.2015	23/60	24/90	47/150
05.19.2015	16/60	14/90	30/150
06.22.2015	29/60	36/90	65/150
Current Change	-13	-22	-35
Overall Change	5	21	26







Best Practice:
Outcome Assessments

In order to establish measurable treatment goals, and to make an objective, valid and reliable determination of meaningful progress toward those goals; to determine treatment effectiveness, and to determine when MMI has been reached, standardized outcome assessments (OA) tools should be utilized during the initial and ALL subsequent examinations.

Review

It is not sufficient to merely “perform” and document the re-exam…

- The re-examination must include the use of outcome assessment tools to measure and compare the patient’s progress towards treatment goals, to determine the effectiveness of treatment provided, and and to help establish when MMI has been reached.

The clinical record must include a summary/assessment of the outcome of this evaluation.

SUBSEQUENT VISITS

Frequency and Duration

Best Practices – Subsequent Visits

- ALL services, and the frequency of services and visits billed to the payors, must be supported by documented medical necessity, **consistent with the patient's chief complaint/clinical findings, diagnoses and treatment plan.**

- The patient's healthcare record must include patient's progress *as it relates to treatment plan.*

- The patient's healthcare record should include evidence that the patient's clinical picture was monitored for improvement, at EACH VISIT, through the use of objective tests, such as range of motion, absence of positive orthopedic, presence or absence of spasm or swelling, presence or absence of positive orthopedic findings, and pain assessment.

More on Subsequent Visits..

- The patient's healthcare record must include significant changes in subjective complaints including, but not limited to, frequency and intensity of pain or discomfort and review of ADL deficit.
- The patient's healthcare record must include response to treatment, any changes in treatment and the rationale for the change.
- The patient's healthcare record should include patient status on discharge and must include summary upon discharge to determine final outcome of treatment rendered.
- The patient's healthcare record should indicate when maximum medical improvement has been reached**. (More on MMI later…)**

More on Subsequent Visits..

- The patient's healthcare record should include S.O.A.P. notes.
- The patient's healthcare record should include the specific segments or regions manipulated.
- The patient's healthcare record should include all modalities and/or therapies performed, the reasons for the therapies, and if time-based, the actual time therapy was performed.
- The patient's healthcare record should include patient education and/or home recommendations and/or any DME.

More on Subsequent Visits..

- The patient's healthcare record must include an evaluation of treatment effectiveness.
- The patient's healthcare record must indicate if care provided is maintenance/supportive care.
- The patient's healthcare record must include prognosis, final diagnoses and discharge date.
- The patient's healthcare record should include summary upon discharge to determine final outcome of treatment rendered.

This is what it needs to look like…

Chiropractic Visit Daily Notes

Patient Name: _____ **Date of Visit**: _____
Attending Doctor: _____

Chief Complaint: ☐ Unchanged ☐ Exacerbation ☐ New Complaint _____

SUBJECTIVE

Symptoms: ☐ Improved ☐ Unchanged ☐ Worse

Pain VAS:

Cervical:	1	2	3	4	5	6	7	8	9	10
Thoracic:	1	2	3	4	5	6	7	8	9	10
Lumbar:	1	2	3	4	5	6	7	8	9	10
Extraspinal	1	2	3	4	5	6	7	8	9	10

Pain Frequency: ☐ Occasional ☐ Intermittent ☐ Constant

ADL - VAS: ☐ Improved ☐ Unchanged ☐ Worse

OBJECTIVE - (Using Key below, mark an X in all the appropriate boxes that apply)
T= Palpable Tenderness **S**=Muscle Spasm **X**=Trigger Point **F**= Joint Fixation **R**= Reduced ROM

	OC	C1	C2	C3	C4	C5	C6	C7	T1	T2	T3	T4	T5	T6	T7	T8	T9	T10	T11	T12
T																				
S																				
X																				
F																				
R																				

	L1	L2	L3	L4	L5	S1	S2	S3	S4	S5	Pelvis	Shoulder	Wrist	Knee	Ankle	Foot
T																
S																
X																
F																
R																

Other: _____
_____

ASSESSMENT – (Related to Treatment Plan)
☐ Improved ☐ Regressed ☐ Unchanged ☐ Approaching MMI ☐ Addt'l Assessment_____

Phase of Care: ☐ Acute ☐ Sub Acute ☐ Chronic ☐ Supportive/ Wellness

Progress of Care: ☐ As Expected ☐ Faster ☐ Slower

Diagnosis: ☐ Unchanged From Treatment Plan
☐ Updated Diagnosis _____
☐ Updated Treatment Plan _____

Doctor's Signature _____

Chiropractic Visit Daily Notes

Patient Name: _____ **Date of Visit**: _____
Attending Doctor: _____

Chief Complaint: ☐ Unchanged ☐ Exacerbation ☐ New Complaint _____

SUBJECTIVE

Symptoms: ☐ Improved ☐ Unchanged ☐ Worse

Pain VAS:

Cervical:	1	2	3	4	5	6	7	8	9	10
Thoracic:	1	2	3	4	5	6	7	8	9	10
Lumbar:	1	2	3	4	5	6	7	8	9	10
Extraspinal	1	2	3	4	5	6	7	8	9	10

Pain Frequency: ☐ Occasional ☐ Intermittent ☐ Constant

ADL - VAS: ☐ Improved ☐ Unchanged ☐ Worse

OBJECTIVE - (Using Key below, mark an X in all the appropriate boxes that apply)
T= Palpable Tenderness **S**=Muscle Spasm **X**=Trigger Point **F**= Joint Fixation **R**= Reduced ROM

	OC	C1	C2	C3	C4	C5	C6	C7	T1	T2	T3	T4	T5	T6	T7	T8	T9	T10	T11	T12
T																				
S																				
X																				
F																				
R																				

	L1	L2	L3	L4	L5	S1	S2	S3	S4	S5	Pelvis	Shoulder	Wrist	Knee	Ankle	Foot
T																
S																
X																
F																
R																

Other: _____
_____

ASSESSMENT – (Related to Treatment Plan)
☐ Improved ☐ Regressed ☐ Unchanged ☐ Approaching MMI ☐ Addt'l Assessment_____

Phase of Care: ☐ Acute ☐ Sub Acute ☐ Chronic ☐ Supportive/ Wellness

Progress of Care: ☐ As Expected ☐ Faster ☐ Slower

Diagnosis: ☐ Unchanged From Treatment Plan
☐ Updated Diagnosis _____
☐ Updated Treatment Plan _____

Doctor's Signature _____

Chiropractic Visit Daily Notes

Patient Name: _____ **Date of Visit**: _____
Attending Doctor: _____

Chief Complaint: ☐ Unchanged ☐ Exacerbation ☐ New Complaint _____

SUBJECTIVE

Symptoms: ☐ Improved ☐ Unchanged ☐ Worse

Pain VAS:

Cervical:	1	2	3	4	5	6	7	8	9	10
Thoracic:	1	2	3	4	5	6	7	8	9	10
Lumbar:	1	2	3	4	5	6	7	8	9	10
Extraspinal	1	2	3	4	5	6	7	8	9	10

Pain Frequency: ☐ Occasional ☐ Intermittent ☐ Constant

ADL - VAS: ☐ Improved ☐ Unchanged ☐ Worse

OBJECTIVE - (Using Key below, mark an X in all the appropriate boxes that apply)
T= Palpable Tenderness **S**=Muscle Spasm **X**=Trigger Point **F**= Joint Fixation **R**= Reduced ROM

	OC	C1	C2	C3	C4	C5	C6	C7	T1	T2	T3	T4	T5	T6	T7	T8	T9	T10	T11	T12
T																				
S																				
X																				
F																				
R																				

	L1	L2	L3	L4	L5	S1	S2	S3	S4	S5	Pelvis	Shoulder	Wrist	Knee	Ankle	Foot
T																
S																
X																
F																
R																

Other: _____
_____

ASSESSMENT – (Related to Treatment Plan)
☐ Improved ☐ Regressed ☐ Unchanged ☐ Approaching MMI ☐ Addt'l Assessment_____

Phase of Care: ☐ Acute ☐ Sub Acute ☐ Chronic ☐ Supportive/ Wellness

Progress of Care: ☐ As Expected ☐ Faster ☐ Slower

Diagnosis: ☐ Unchanged From Treatment Plan
☐ Updated Diagnosis _____
☐ Updated Treatment Plan _____

Doctor's Signature _____

Chiropractic Visit Daily Notes

Patient Name: _____ **Date of Visit**: _____
Attending Doctor: _____

Chief Complaint: ☐ Unchanged ☐ Exacerbation ☐ New Complaint _____

SUBJECTIVE

Symptoms: ☐ Improved ☐ Unchanged ☐ Worse

Pain VAS:

Cervical:	1	2	3	4	5	6	7	8	9	10
Thoracic:	1	2	3	4	5	6	7	8	9	10
Lumbar:	1	2	3	4	5	6	7	8	9	10
Extraspinal	1	2	3	4	5	6	7	8	9	10

Pain Frequency: ☐ Occasional ☐ Intermittent ☐ Constant

ADL - VAS: ☐ Improved ☐ Unchanged ☐ Worse

OBJECTIVE - (Using Key below, mark an X in all the appropriate boxes that apply)
T= Palpable Tenderness **S**=Muscle Spasm **X**=Trigger Point **F**= Joint Fixation **R**= Reduced ROM

	OC	C1	C2	C3	C4	C5	C6	C7	T1	T2	T3	T4	T5	T6	T7	T8	T9	T10	T11	T12
T																				
S																				
X																				
F																				
R																				

	L1	L2	L3	L4	L5	S1	S2	S3	S4	S5	Pelvis	Shoulder	Wrist	Knee	Ankle	Foot
T																
S																
X																
F																
R																

Other: _____
_____

ASSESSMENT – (Related to Treatment Plan)
☐ Improved ☐ Regressed ☐ Unchanged ☐ Approaching MMI ☐ Addt'l Assessment_____

Phase of Care: ☐ Acute ☐ Sub Acute ☐ Chronic ☐ Supportive/ Wellness

Progress of Care: ☐ As Expected ☐ Faster ☐ Slower

Diagnosis: ☐ Unchanged From Treatment Plan
☐ Updated Diagnosis _____
☐ Updated Treatment Plan _____

Doctor's Signature _____

Chiropractic Visit Daily Notes

Patient Name: _____ **Date of Visit**: _____
Attending Doctor: _____

Chief Complaint: ☐ Unchanged ☐ Exacerbation ☐ New Complaint _____

SUBJECTIVE

Symptoms: ☐ Improved ☐ Unchanged ☐ Worse

Pain VAS:

Cervical:	1	2	3	4	5	6	7	8	9	10
Thoracic:	1	2	3	4	5	6	7	8	9	10
Lumbar:	1	2	3	4	5	6	7	8	9	10
Extraspinal	1	2	3	4	5	6	7	8	9	10

Pain Frequency: ☐ Occasional ☐ Intermittent ☐ Constant

ADL - VAS: ☐ Improved ☐ Unchanged ☐ Worse

OBJECTIVE - (Using Key below, mark an X in all the appropriate boxes that apply)
T= Palpable Tenderness **S**=Muscle Spasm **X**=Trigger Point **F**= Joint Fixation **R**= Reduced ROM

	OC	C1	C2	C3	C4	C5	C6	C7	T1	T2	T3	T4	T5	T6	T7	T8	T9	T10	T11	T12
T																				
S																				
X																				
F																				
R																				

	L1	L2	L3	L4	L5	S1	S2	S3	S4	S5	Pelvis	Shoulder	Wrist	Knee	Ankle	Foot
T																
S																
X																
F																
R																

Other: _____
_____

ASSESSMENT – (Related to Treatment Plan)
☐ Improved ☐ Regressed ☐ Unchanged ☐ Approaching MMI ☐ Addt'l Assessment_____

Phase of Care: ☐ Acute ☐ Sub Acute ☐ Chronic ☐ Supportive/ Wellness

Progress of Care: ☐ As Expected ☐ Faster ☐ Slower

Diagnosis: ☐ Unchanged From Treatment Plan
☐ Updated Diagnosis _____
☐ Updated Treatment Plan _____

Doctor's Signature _____

Patient Name: _____ **Date of Visit**: _____
Attending Doctor: _____

PLAN

Adjusted Spinal Regions: **OC** **C**: 1 2 3 4 5 6 7 **TH**: 1 2 3 4 5 6 7 8 9 10 11 12
L: 1 2 3 4 5 **Sacrum**: left / right **Pelvis**: left / right

Adjusted Extra- Spinal Regions: **Wrist**: left / right **Elbow**: left / right **Shoulder**: left / right
Knee: left / right **Ankle**: left / right **Foot**: left / right
TMJ: left / right **Other**: _____ **Other**: _____

Modalities:

	Cervical	Thoracic	Lumbar	Sacrum Pelvis	Extra Spinal	Time	# of Units
97014 - Elect. Stim.							
97012 – Mech. Traction							
97010 - Hot Pack							
97010 - Ice Pack							
97124 – Hydrotherapy						/Min	
97035 – Ultrasound						/Min	
97140 - Manual Therapy						/Min	
97112 – NMR						/Min	
97110 - Thera. Exercises						/Min	
97124 – Massage						/Min	
						/Min	
						/Min	
						/Min	
						/Min	

Notes: _____
_____

Home Care Instructions: _____

☐ Pt. Tolerated Tx. Well ☐ Pt. Responded Well ☐ Continue Current Tx. Plan, as prescribed
☐ Adverse Reaction to Treatment? _____
☐ Modify Tx Plan _____
☐ Next Scheduled Re-Evaluation: 1 week 2 weeks 3 weeks 4 weeks other _____

Next Visit Date: _____ **Attending Doctor's Signature**: _____

Patient Name: _____ **Date of Visit**: _____
Attending Doctor: _____

PLAN

Adjusted Spinal Regions: **OC** **C**: 1 2 3 4 5 6 7 **TH**: 1 2 3 4 5 6 7 8 9 10 11 12
L: 1 2 3 4 5 **Sacrum**: left / right **Pelvis**: left / right

Adjusted Extra- Spinal Regions: **Wrist**: left / right **Elbow**: left / right **Shoulder**: left / right
Knee: left / right **Ankle**: left / right **Foot**: left / right
TMJ: left / right **Other**: _____ **Other**: _____

Modalities:

	Cervical	Thoracic	Lumbar	Sacrum Pelvis	Extra Spinal	Time	# of Units
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97124 – Hydrotherapy						/Min	
97035 – Ultrasound						/Min	
97140 - Manual Therapy						/Min	
97112 – NMR						/Min	
97110 - Thera. Exercises						/Min	
97124 – Massage						/Min	
						/Min	
						/Min	
						/Min	
						/Min	

Notes: _____
_____

Home Care Instructions: _____

☐ Pt. Tolerated Tx. Well ☐ Pt. Responded Well ☐ Continue Current Tx. Plan, as prescribed
☐ Adverse Reaction to Treatment? _____
☐ Modify Tx Plan _____
☐ Next Scheduled Re-Evaluation: 1 week 2 weeks 3 weeks 4 weeks other _____

Next Visit Date: _____ **Attending Doctor's Signature**: _____

Notes in action…

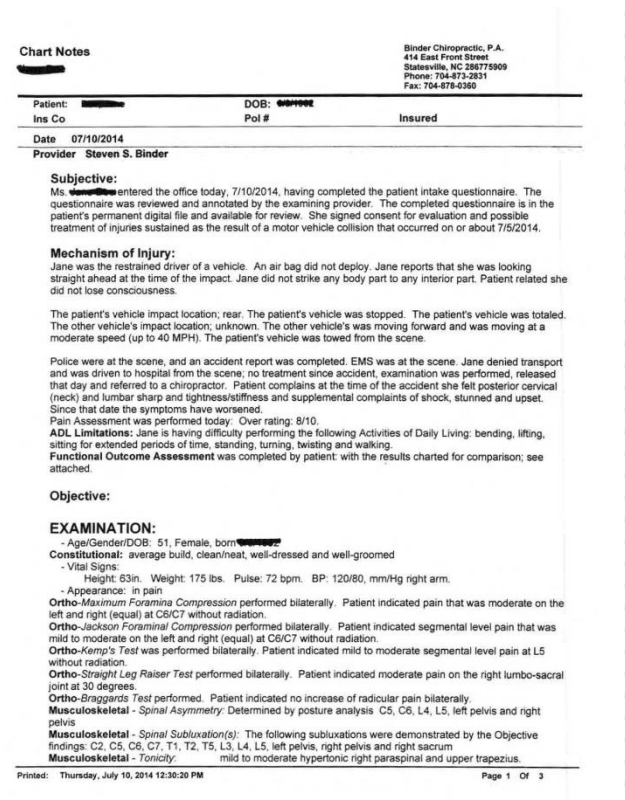

Chart Notes

[redacted]

Binder Chiropractic, P.A.
414 East Front Street
Statesville, NC 286775909
Phone: 704-873-2831
Fax: 704-878-0360

Patient: [redacted] DOB: [redacted]
Ins Co Pol # Insured

Date 07/10/2014
Provider Steven S. Binder

Subjective:
Ms. [redacted] entered the office today, 7/10/2014, having completed the patient intake questionnaire. The questionnaire was reviewed and annotated by the examining provider. The completed questionnaire is in the patient's permanent digital file and available for review. She signed consent for evaluation and possible treatment of injuries sustained as the result of a motor vehicle collision that occurred on or about 7/5/2014.

Mechanism of Injury:
Jane was the restrained driver of a vehicle. An air bag did not deploy. Jane reports that she was looking straight ahead at the time of the impact. Jane did not strike any body part to any interior part. Patient related she did not lose consciousness.

The patient's vehicle impact location; rear. The patient's vehicle was stopped. The patient's vehicle was totaled. The other vehicle's impact location; unknown. The other vehicle's was moving forward and was moving at a moderate speed (up to 40 MPH). The patient's vehicle was towed from the scene.

Police were at the scene, and an accident report was completed. EMS was at the scene. Jane denied transport and was driven to hospital from the scene; no treatment since accident, examination was performed, released that day and referred to a chiropractor. Patient complains at the time of the accident she felt posterior cervical (neck) and lumbar sharp and tightness/stiffness and supplemental complaints of shock, stunned and upset. Since that date the symptoms have worsened.
Pain Assessment was performed today: Over rating: 8/10.
ADL Limitations: Jane is having difficulty performing the following Activities of Daily Living: bending, lifting, sitting for extended periods of time, standing, turning, twisting and walking.
Functional Outcome Assessment was completed by patient: with the results charted for comparison; see attached.

Objective:

EXAMINATION:
- Age/Gender/DOB: 51, Female, born [redacted]

Constitutional: average build, clean/neat, well-dressed and well-groomed
- Vital Signs:
  Height: 63in. Weight: 175 lbs. Pulse: 72 bpm. BP: 120/80, mm/Hg right arm.
- Appearance: in pain

Ortho-*Maximum Foramina Compression* performed bilaterally. Patient indicated pain that was moderate on the left and right (equal) at C6/C7 without radiation.
Ortho-*Jackson Foraminal Compression* performed bilaterally. Patient indicated segmental level pain that was mild to moderate on the left and right (equal) at C6/C7 without radiation.
Ortho-*Kemp's Test* was performed bilaterally. Patient indicated mild to moderate segmental level pain at L5 without radiation.
Ortho-*Straight Leg Raiser Test* performed bilaterally. Patient indicated moderate pain on the right lumbo-sacral joint at 30 degrees.
Ortho-*Braggards Test* performed. Patient indicated no increase of radicular pain bilaterally.
Musculoskeletal - *Spinal Asymmetry:* Determined by posture analysis C5, C6, L4, L5, left pelvis and right pelvis
Musculoskeletal - *Spinal Subluxation(s):* The following subluxations were demonstrated by the Objective findings: C2, C5, C6, C7, T1, T2, T5, L3, L4, L5, left pelvis, right pelvis and right sacrum
Musculoskeletal - *Tonicity:* mild to moderate hypertonic right paraspinal and upper trapezius.

Printed: Thursday, July 10, 2014 12:30:20 PM Page 1 Of 3

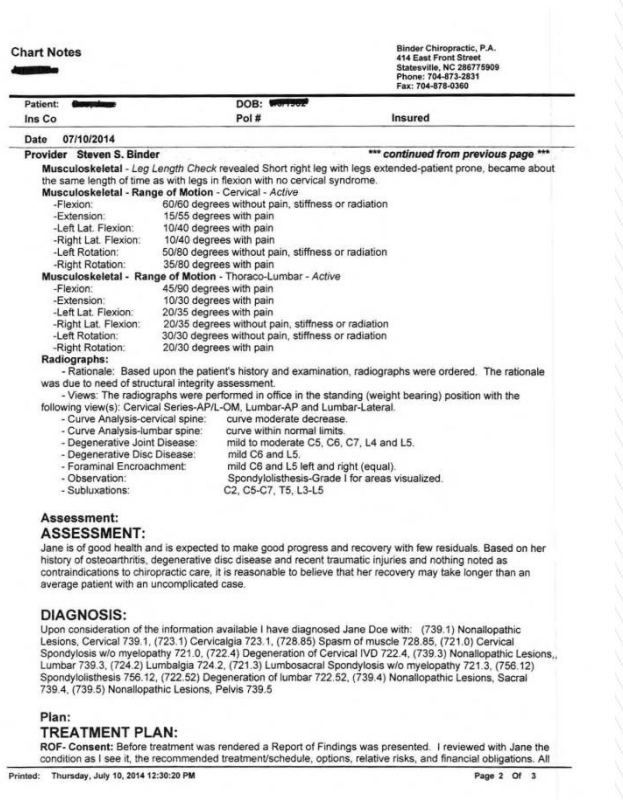

Chart Notes

[redacted]

Binder Chiropractic, P.A.
414 East Front Street
Statesville, NC 286775909
Phone: 704-873-2831
Fax: 704-878-0360

Patient: [redacted] DOB: [redacted]
Ins Co Pol # Insured

Date 07/10/2014
Provider Steven S. Binder *** *continued from previous page* ***

Musculoskeletal - *Leg Length Check* revealed Short right leg with legs extended-patient prone, became about the same length of time as with legs in flexion with no cervical syndrome.
Musculoskeletal - Range of Motion - Cervical - *Active*
-Flexion: 60/60 degrees without pain, stiffness or radiation
-Extension: 15/55 degrees with pain
-Left Lat. Flexion: 10/40 degrees with pain
-Right Lat. Flexion: 10/40 degrees with pain
-Left Rotation: 50/80 degrees without pain, stiffness or radiation
-Right Rotation: 35/80 degrees with pain
Musculoskeletal - Range of Motion - Thoraco-Lumbar - *Active*
-Flexion: 45/90 degrees with pain
-Extension: 10/30 degrees with pain
-Left Lat. Flexion: 20/35 degrees with pain
-Right Lat. Flexion: 20/35 degrees without pain, stiffness or radiation
-Left Rotation: 30/30 degrees without pain, stiffness or radiation
-Right Rotation: 20/30 degrees with pain
Radiographs:
- Rationale: Based upon the patient's history and examination, radiographs were ordered. The rationale was due to need of structural integrity assessment.
- Views: The radiographs were performed in office in the standing (weight bearing) position with the following view(s): Cervical Series-AP/L-OM, Lumbar-AP and Lumbar-Lateral.
- Curve Analysis-cervical spine: curve moderate decrease.
- Curve Analysis-lumbar spine: curve within normal limits.
- Degenerative Joint Disease: mild to moderate C5, C6, C7, L4 and L5.
- Degenerative Disc Disease: mild C6 and L5.
- Foraminal Encroachment: mild C6 and L5 left and right (equal).
- Observation: Spondylolisthesis-Grade I for areas visualized.
- Subluxations: C2, C5-C7, T5, L3-L5

Assessment:
ASSESSMENT:
Jane is of good health and is expected to make good progress and recovery with few residuals. Based on her history of osteoarthritis, degenerative disc disease and recent traumatic injuries and nothing noted as contraindications to chiropractic care, it is reasonable to believe that her recovery may take longer than an average patient with an uncomplicated case.

DIAGNOSIS:
Upon consideration of the information available I have diagnosed Jane Doe with: (739.1) Nonallopathic Lesions, Cervical 739.1, (723.1) Cervicalgia 723.1, (728.85) Spasm of muscle 728.85, (721.0) Cervical Spondylosis w/o myelopathy 721.0, (722.4) Degeneration of Cervical IVD 722.4, (739.3) Nonallopathic Lesions,, Lumbar 739.3, (724.2) Lumbalgia 724.2, (721.3) Lumbosacral Spondylosis w/o myelopathy 721.3, (756.12) Spondylolisthesis 756.12, (722.52) Degeneration of lumbar 722.52, (739.4) Nonallopathic Lesions, Sacral 739.4, (739.5) Nonallopathic Lesions, Pelvis 739.5

Plan:
TREATMENT PLAN:
ROF- Consent: Before treatment was rendered a Report of Findings was presented. I reviewed with Jane the condition as I see it, the recommended treatment/schedule, options, relative risks, and financial obligations. All

Printed: Thursday, July 10, 2014 12:30:20 PM Page 2 Of 3

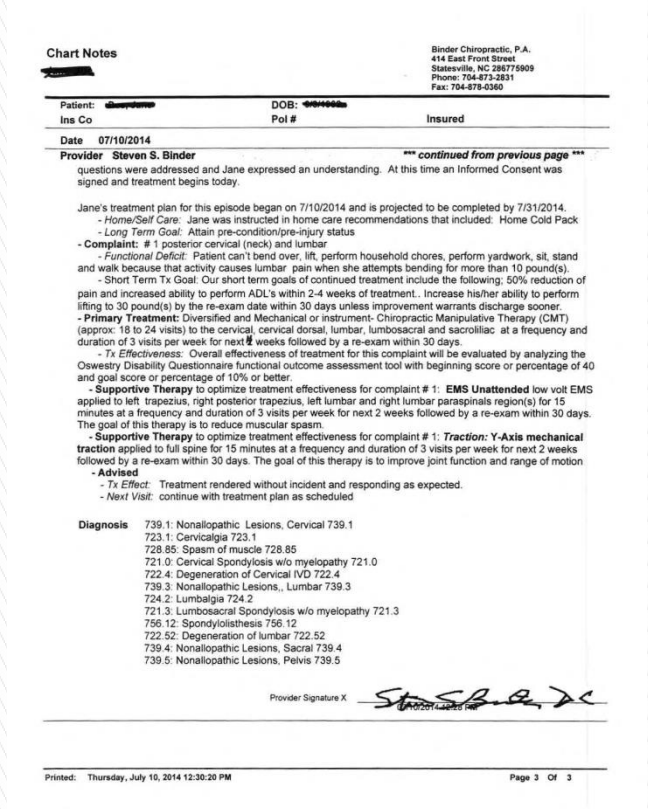

Chart Notes

[redacted]

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414 East Front Street
Statesville, NC 286775909
Phone: 704-873-2831
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Patient: [redacted] DOB: [redacted]
Ins Co Pol # Insured

Date 07/10/2014

Provider Steven S. Binder *** continued from previous page ***

questions were addressed and Jane expressed an understanding. At this time an Informed Consent was signed and treatment begins today.

Jane's treatment plan for this episode began on 7/10/2014 and is projected to be completed by 7/31/2014.
- *Home/Self Care:* Jane was instructed in home care recommendations that included: Home Cold Pack
- *Long Term Goal:* Attain pre-condition/pre-injury status

- Complaint: # 1 posterior cervical (neck) and lumbar
- *Functional Deficit:* Patient can't bend over, lift, perform household chores, perform yardwork, sit, stand and walk because that activity causes lumbar pain when she attempts bending for more than 10 pound(s).
- Short Term Tx Goal: Our short term goals of continued treatment include the following; 50% reduction of pain and increased ability to perform ADL's within 2-4 weeks of treatment.. Increase his/her ability to perform lifting to 30 pound(s) by the re-exam date within 30 days unless improvement warrants discharge sooner.

- Primary Treatment: Diversified and Mechanical or instrument- Chiropractic Manipulative Therapy (CMT) (approx: 18 to 24 visits) to the cervical, cervical dorsal, lumbar, lumbosacral and sacroiliac at a frequency and duration of 3 visits per week for next 2 weeks followed by a re-exam within 30 days.
- *Tx Effectiveness:* Overall effectiveness of treatment for this complaint will be evaluated by analyzing the Oswestry Disability Questionnaire functional outcome assessment tool with beginning score or percentage of 40 and goal score or percentage of 10% or better.

- Supportive Therapy to optimize treatment effectiveness for complaint # 1: **EMS Unattended** low volt EMS applied to left trapezius, right posterior trapezius, left lumbar and right lumbar paraspinals region(s) for 15 minutes at a frequency and duration of 3 visits per week for next 2 weeks followed by a re-exam within 30 days. The goal of this therapy is to reduce muscular spasm.

- Supportive Therapy to optimize treatment effectiveness for complaint # 1: ***Traction:*** **Y-Axis mechanical traction** applied to full spine for 15 minutes at a frequency and duration of 3 visits per week for next 2 weeks followed by a re-exam within 30 days. The goal of this therapy is to improve joint function and range of motion

- Advised
- *Tx Effect:* Treatment rendered without incident and responding as expected.
- *Next Visit:* continue with treatment plan as scheduled

Diagnosis
739.1: Nonallopathic Lesions, Cervical 739.1
723.1: Cervicalgia 723.1
728.85: Spasm of muscle 728.85
721.0: Cervical Spondylosis w/o myelopathy 721.0
722.4: Degeneration of Cervical IVD 722.4
739.3: Nonallopathic Lesions,, Lumbar 739.3
724.2: Lumbalgia 724.2
721.3: Lumbosacral Spondylosis w/o myelopathy 721.3
756.12: Spondylolisthesis 756.12
722.52: Degeneration of lumbar 722.52
739.4: Nonallopathic Lesions, Sacral 739.4
739.5: Nonallopathic Lesions, Pelvis 739.5

Provider Signature X [redacted] DC
07/07/2014 10:23 PM

Printed: Thursday, July 10, 2014 12:30:20 PM Page 3 Of 3

Best Practices- CMT

Best Practices – CMT documentation…

The clinical record will :

- Include all manipulations performed.
- Include the location and specific segments or regions manipulated.
- Include documentation to demonstrate subluxations (by either radiographs or physical examination). If subluxation is demonstrated by physical examination, the clinical record will establish that two of the four P.A.R.T. criteria are met (pain, asymmetry, range of motion, tissues changes); one of which must be range of motion or asymmetry.

Best Practices – CMT documentation…

The clinical record will :

Substantiate that manipulations reported to payors are consistent with the patient's chief complaint, objective clinical findings, diagnoses and treatment plan.

Best Practices-Modalities/Therapies

Best Practices – Therapies/Modalities/DME

The clinical record will:

- Include all DME/modalities/therapies performed, the rationale for each, duration of each and areas of application, as applicable.
- Substantiate that therapies/modalities/DME are consistent with the patient's chief complaint, clinical findings, diagnoses and treatment plan.
- If time-based therapies are performed (constant attendance or therapeutic procedures), the record will reflect the actual time the therapy was performed. (Ex: 15 minutes or 1 unit)

Best Practices – Therapies/Modalities/DME

During the initial phase of care, no more than 2 therapies or modalities per visits are considered usual or customary.

There should be a reduction in the number of therapies as the patient's condition improved.

Best Practices-Radiology

Best Practice – Radiology

- For ALL radiology services provided and billed, the following factors must be documented:
  - A. Providers must document all radiology studies performed and/or interpreted in the office.
  - B. The area(s) initially x-rayed must be medically necessary and consistent with the patient's initial chief complaint.
  - C. Subsequent x-rays must be medically necessary, and consistent with the patient's complaint, clinical findings, diagnoses and treatment plan.

Best Practice – Radiology

- D. A written radiology report to document the provider's interpretation of the radiograph(s) must be maintained in the patient's healthcare record. These reports must be signed or initialed by the provider and should include:
  - 1. Patient identifying information (patient name, DOB, etc.)
  - 2. Date of study as well as an accurate description of the radiological findings
  - 3. Impressions
  - 4. Recommendations for follow-up studies that may be needed to reach a final diagnostic impression

Best Practice – Radiology

- E. The specific area(s) x-rayed must be documented
- F. The date of the study must be documented
- G. There should be documented, supporting evidence that clinical findings support the need for repeat x-rays

Best Practice – Radiology

- **Routine repetitive x-rays within a 90 day period require the following documentation:**

  1. Evidence of a new injury reported for the same area as the initially reported area

  2. An initially identified pathology or biomechanical aberration requiring further investigation

  3. A new symptom in the same area appears which was not present initially

Best Practice – Radiology

- Radiographs are generally considered *medically necessary* only for the purposes of diagnosing specific problem area(s) documented as a chief complaint with supporting objective clinical findings.
- For billing purposes, an x-ray “view” is a separate exposure to radiation. Therefore, full spine x-rays cut into sections do not constitute multiple views, unless multiple exposures are taken.
- Single view x-rays without opposing views are not considered of diagnostic quality. An occasional “spot shot,” or single view, may be performed as a follow-up to review a specific area in question.

Chiropractic Radiology Report

Patient Name: _____ **D.O.B:** _____ **File #:** _____
Series: _____ **Exam Date:** _____
Report Date: _____

FILMS TAKEN DUE TO - SUSPECT: DEGENERATION___INFECTION___NEOPLASM___TUMOR___FRACTURE___
VERTEBRAL SUBLUXATION _____

KEY: check if unremarkable,
circle if present.
slight - mild - moderate - severere
1-24% 25-49% 50-74% 75-100%

ALIGNMENT
Scoliosis:
C/S Levo-scoliosis-Dextro-scoliosis Si Mi M S
T/S Levo-scoliosis-Dextro-scoliosis Si Mi M S
L/S Levo-scoliosis-Dextro-scoliosis Si Mi M S
T/S Kyphosis: increased decreased Si Mi M S
Lordosis:
Georges Line: Smooth or Break at _____
C/S Lordosis: Increased decreased Si Mi M S
C/S Loss of Lordosis
C/S Reversal of Lordosis Si Mi M S
Swischuk, Spinal-Lamina Line: C123
L/S: Lordosis Increased Decreased Si Mi M S
Head:
Tilt: Left Right Si Mi M S
Carriage: forward: Si Mi M S
Pelvic Unleveling:_____mm high on Right - Left
Subluxations: _____

Other:

CARTILAGE
Articular Disc Thinning: Mild Mod Severe
Cervical - decreased at _____
Thoracic - decreased a _____
Lumbar - decreased at _____

Cervical - Sclerosis at _____
Thoracic Sclerosis at _____
Lumbar - Scleross at _____

Sacral-Iliac Joints, comments, _____

Acetabular Joint Spaces: comments _____

Costal cartilages comments:

Nuclear Impressions,
Vacuum Phenomenon at _____

Other:

BONE
Bone Density: Good -- Fair -- Poor
Congenital Anomalies: Sella Turcica <16x12mm
Cervical Rib, Dens Posterior Ponticle
Foramina Occlusion: Seg. _____ Si Mi M S
Spinal Canal Stenosis:
Si Mi M S C/S >16,14,13,12mm
Si Mi M S L/S > 15mm (Lat. View)
Seg - ____. ____mm.
Anterior/Retro/ Spondylolisthesis, Spondylosis
Segment _____Grade _____
Spina Bifida: Segment _____
Transitional Segment: _____
RA & Down's Syn. C/S Flex Lat. View X- Ray Taken
Trauma: Recent or Past Hx of: _____
Compression/Fx_____ Schmorl's node _____
Arthritides: Scheuermans's, levels _____
Pagets, Osteoarthrosis, Seg. _____
Infection Suspected at _____
Other:

SOFT TISSUES
ADI (<4mm)
RPI (<12mm) (RLI (<22mm) (>12 hrs. post trauma)
Lung Apices Clear
Tracheal Air Sh Deviation
Calcification:
Trachea Larynx
Dilation of Aorta?_____cm
Other:
PATHOLOGIES:
None Apparent
Referral to: _____for further
investigation of _____
CLINICAL IMPRESSIONS:

Custodian of X-Rays:

Date reviewed: _____

Radiology report reviewed by: _____
(provider name)

IMPORTANT BILLING NOTES: Both the CMT codes and the E/M codes include a review of any imaging studies so when a patient brings in imaging studies *that were taken elsewhere*, it is not appropriate to charge for the review of those films (76140) nor is it appropriate to append the code with -26 (professional component).

Code 76140 (Consultation on x-ray - made elsewhere) This code should ONLY be reported by radiologists who performs a subsequent reading of the imaging study *but who do not actually see the patient.*

HNSRadhm120709

Medical Necessity

Biggest problem found during audits that result in post payment repayments!

Best Practices –Medical Necessity

Insurance isn't there to take care of everything. It is there to take care or reimburse for services outlined in the Corporate Medical Policy.

Payor Requirements – Medical Necessity

- **To establish the medical necessity** for services provided and billed to payors, those services must be consistent with the Payor Policies and **with documented the chief complaint/clinical findings, diagnoses and treatment plan.**

- Clinical examination findings must *objectively* substantiate the medical necessity of services provided and billed to payors

Using Clinical Outcome Assessment Forms to Establish Medical Necessity.

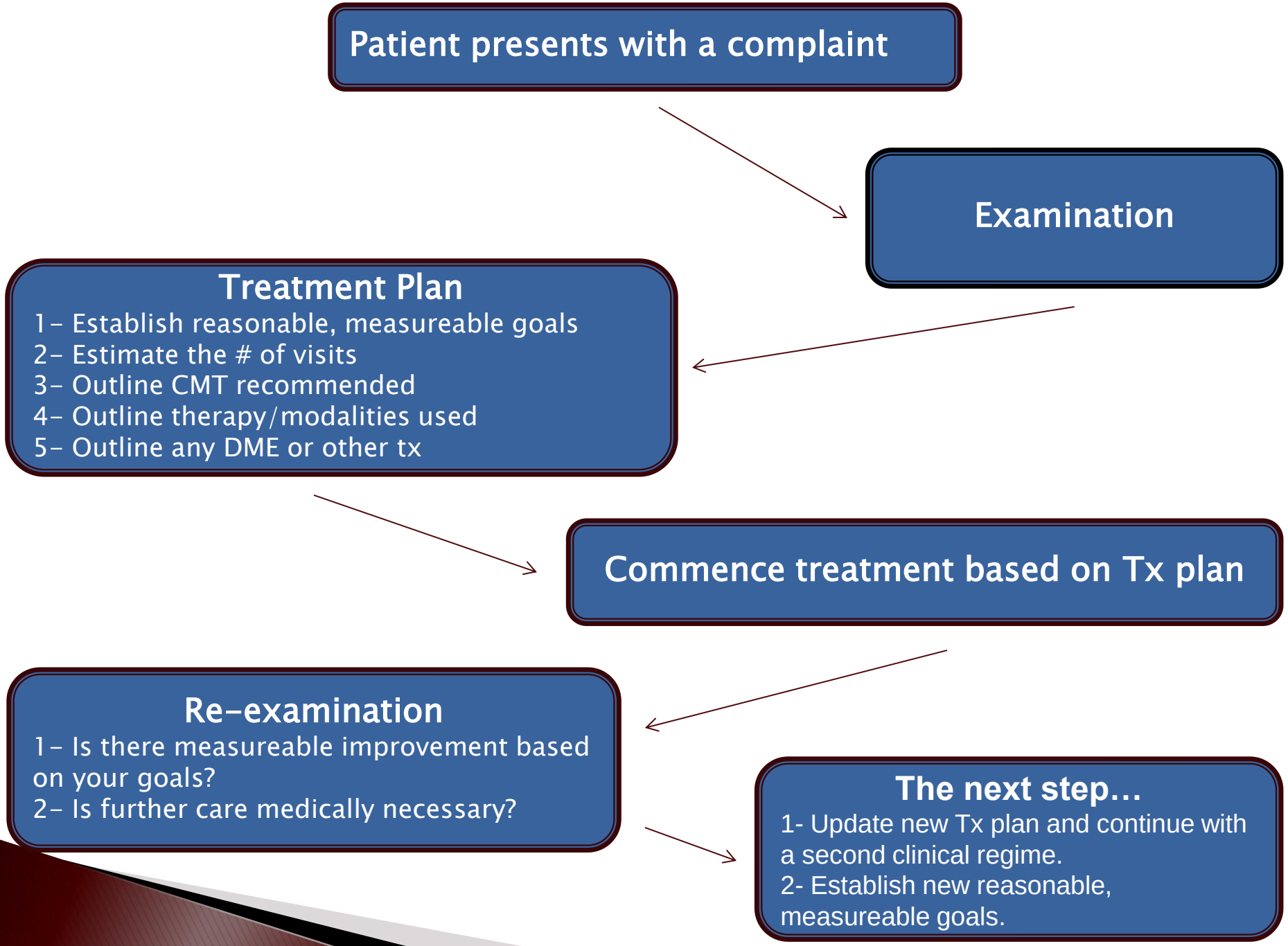
"The use of adjustments, rehabilitative exercises and subjective/objective outcome measures are critical when a functional approach is taken.

Outcome assessments keep everyone apprised of the progress (if any) of the patient in response to health care services.'

Kim Christensen, DC, DACRB, CCSP, CSCS

So what's medical necessity really mean?

Getting to the flow of it!


Patient presents with a complaint
Examination
Treatment Plan
1- Establish reasonable, measureable goals
2- Estimate the # of visits
3- Outline CMT recommended
4- Outline therapy/modalities used
5- Outline any DME or other tx
Commence treatment based on Tx plan
Re-examination
1- Is there measureable improvement based on your goals?
2- Is further care medically necessary?
The next step…
1- Update new Tx plan and continue with a second clinical regime.
2- Establish new reasonable, measureable goals.

Maintenance/Supportive Care

What is Maintenance Care?

The ACA has published the following definition for maintenance care:

"Preventive/Maintenance Care: Elective healthcare that is typically long-term, by definition not therapeutically necessary but is provided at preferably regular intervals to prevent disease, prolong life, promote health and enhance the quality of life. This care may be provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration or it may be initiated with patients without symptoms in order to promote health and to prevent future problems. This care may incorporate screening/evaluation procedures designed to identify developing risks or problems that may pertain to the patient's health status and give care/advice for these. Preventive/maintenance care is provided to optimize a patient's health."

Maintenance begins when the therapeutic goals of a treatment plan have been achieved and when no further functional progress is apparent or expected to occur.

So What IS Supportive Care?

The American Chiropractic Association published the following definitions:

- **"Supportive Care:** Long-term treatment/care...for patients who have reached maximum therapeutic benefit, but who fail to sustain benefit and progressively deteriorate when there are periodic trials of treatment withdrawal.

- Supportive care follows appropriate application of active and passive care including rehabilitation and/or lifestyle modifications. Supportive care is appropriate when alternative care options, including home-based self-care or referral, have been considered and/or attempted. Supportive care may be inappropriate when it interferes with other appropriate primary care, or when risk of supportive care outweighs its benefit, i.e. physician/treatment dependence, somatization, illness behavior or secondary gain."

Maintenance and Supportive care is NOT covered by insurance!

The inappropriate billing of **maintenance and/or supportive care** is

the number 1 reason for CMS and payor audits of chiropractic health care records and recoupments of funds previously paid to the providers.

What is MMI?

Maximal Medical Improvement

Maximum medical improvement (MMI) occurs when a patient with an illness or injury reaches a state where additional, objective, **measurable** improvement cannot reasonably be expected from additional treatment, and/or or when a treatment plateau in a person's healing process is reached.

Maximal Medical Improvement

- In its simplest form, **maximum medical improvement, or MMI**, means that **additional treatment is not likely to produce additional functional improvement.**

- (This is not to say that the patient may not regress in the absence of further care, but if so, treatment would be "supportive care" which is NOT covered by insurance.)

MMI –OAs

A comparison of the results from the OAs done at the initial exam to the results of the OAs at all subsequent re-exams is necessary for determining when ***MMI has been reached (or not reached).***

Tx Goals and MMI

If you have not initially established *reasonable, objective, measurable treatment goals*, you can't objectively evaluate treatment effectiveness.

OAs and MMI

If you aren't measuring patient progress
toward treatment goals and effectiveness of treatment
(using OAs)
you will not be able to objectively determine when MMI
has been reached!

Maximal Medical Improvement

When the patient has reached MMI this information should be communicated to him/her.

WHAT TO SAY

"While continued care is recommended, we have reached the goals of your treatment and additional care is not likely to produce additional **functional improvement"**.

As soon as MMI has been reached

the patient MUST be released, referred, or switched from active care to "maintenance/supportive care" and those visits *must not be billed to the payor*.

Coding

Coding doesn't have to be difficult. It's one of the ways you tell your story.

Time Based Codes

- The inappropriate use and reporting of **time based therapies** increases your chances of post-payment audits! Payors are paying close attention to ALL time based codes reported with particular attention to CPT codes 97124 (massage) and 97140 (manual therapy). Nationally, post payment chiropractic audits have revealed that these codes are often reported without appropriate documented medical necessity for those services, and/or for the *number of units reported*.

- All time based therapies (constant attendance and therapeutic procedures) are billed in 15 minute increments. When these services are provided for *less than 15 minutes, the code must be appended with Modifier 52.* **Please remember that the actual time the service was performed must be documented in the patient's healthcare record.**

Time-based Therapies (8 Minute rule)

- 0 Units < 8 Minutes
- 1 Unit >= 8 Minutes and <= 22 minutes
- 2 Units >= 23 Minutes and <= 37 minutes
- 3 Units >= 38 Minutes and <= 52 minutes
- 4 Units >= 53 Minutes and <= 67 minutes

- **Timed therapies are calculated independent of untimed therapies.**

Helpful Reminders...Time Based Codes

- Documentation contained in the healthcare record must clearly establish the medical necessity for services reported.
- Services must be consistent with chief complaint/clinical findings, dx, treatment plan, and BOCE *Practice Guides* and payor corporate medical policies.
- **There should be a reduction in the use of therapies as the patient's condition improves.**

Codes to be careful with…

- 97032- attended muscle stim.
- 97035- ultrasound
- 97140- myofascial release
- 97124- massage
- 97530- physician assisted exercise
- 97535- ADL's
- LEVEL OF E/M and CMT CODES REPORTED

- NOTE: Time **IS** a factor in the description of constant attendance modalities and cannot exceed 4 (15 minute) units of time.

Coding Pitfalls

Generally, all codes require descriptive documentation regarding where they are being used. Also, some codes require specific time lengths and methods of application in order to be documented properly and be reimbursed by a given carrier. If you do not maintain such a standard in your office, you will find that insurance companies will begin to audit your notes and may demand payments returned.

Review of commonly misused codes

- 97039- Unlisted Modality
- 97140- Myofascial Release
- 989***- CMT codes
- E/M Codes
- 76140- Radiology Consultation Codes
- -26 modifier- Professional Component
- 99241-99245- Consultation codes
- DME
- Attended Modality codes
  - 97035, 97032, 97140, 97124, 97530, etc.

Review of Proper Coding and Use of Modifiers

- When applicable, providers must use appropriate modifiers when reporting and billing chiropractic services to a payor. The use and/or need for the modifier must be supported by appropriate documentation in the healthcare record.

Modifier – 59 – Distinct Procedural Service.

- Indicates that a procedure or service is distinct or separate from other services performed on the same day.
- Most payors require the use of modifier 59 with certain codes and without this modifier the claim will not be correctly adjudicated. For this reason, it is important to understand what each payor policies are with regards to this modifier.
- Important note: if you perform a time based service together with an E/M and/or CMT service that must be appended by modifier 59, and you also provide the service for less than 15 minutes, you must append the code with the modifier 59 not with a modifier 52. However, your documentation must reflect the actual time you provided the service (i.e. 10 minutes).

- **Modifier – 25 - Significant, separately identifiable E/M Service**

  Please note – this modifier is only to be used with E/M codes and should not be added to any other code.

  If you are billing an E/M service in addition to a chiropractic manipulation code (98940, 98941, 98942) for the same patient on the same date of service, you should append the E/M code with the modifier 25.

- **Modifier – 51 - Multiple Procedures**

  In general, if you are billing for a spinal manipulation as well as an extraspinal manipulation for the same patient on the same date of service, it is recommended that you append the code for extraspinal manipulation using modifier 51.

- **Modifier – 52 - Reduced Services**

  If you are reporting a time-based procedure and you provide the service for less than the full unit (15 minutes) but at least 8 minutes, in general, you should append this code with a modifier – 52.

- **Exception:** If the service is reported with CMT or E/M service and *requires the use of modifier 59 to prevent bundling*, then always append with the modifier 59.
- **However, your documentation must reflect the actual time you provided the service (i.e. 10 minutes).**
-

- **Modifier – 26 – Professional Component**

  This modifier indicates the provider is reporting the professional component ONLY for a service. This code would be appropriately reported by a Chiropractic Radiologist who did not actually see the patient but interpreted the study. If the study is performed in your office and you interpreted the study, the CPT code for the study should not be appended with any modifier. Please note - the pre-service work included in the CMT codes includes imaging review and the review of imaging studies included in the CMT service applies regardless of whether the studies were performed in your office or if the patient brings films to you that were taken elsewhere.

Case scenarios in your practice that are commonly miss or under coded.

- The new injury….
- Aggravations or exacerbations…
- Additional complaints during a course of care…
- Re-examinations… (BOE requirement)
- Etc.

What the Carriers want to see in your notes

Your record must 'Tell a story'

- A doctor, case manager, investigator or other records professional should be able to understand the "why" of what you're doing with a patient, where you're doing your treatment on a patient and how they are responding to the treatment. Simple!!! (treatment must be based on DOCUMENTED, OBJECTIVE CLINICAL FINDINGS!)

- Volume is not better than content! Some doctors think that long notes that are generated by software programs keep them out of trouble. Not so! Better to tell the story in your own words.

This is what they DON'T want to find...

- **LACK OF DOCUMENTED MEDICAL NECESSITY FOR SERVICE BILLED**
- **Failure to adhere to Corporate Medical Policies (CMP)**
- **Not filing claims for covered services provided (including free exams, xrays...)**
- **Waiving/reducing co-payments, deductibles and/or co-insurance**
- Use of manual therapy (97140) together with CMT codes, without establishing/documenting medical necessity
- Inappropriate and overuse of massage therapy (97124)
- Lack of reduction in therapies as patient condition improves
- Upcoding CMT and E/M codes
- Billing for maintenance/supportive care
- Inappropriate billing for consultations
- Inappropriate billing for radiology consults
- Improperly documenting time based therapies

Best Protection – Self Audits

Staying compliant:

- Self audits are a way for each provider and their staff to systematically review patient healthcare records to determine compliance. Rather than wait till you "get the call" from a carrier, this is a way that you can be pro-active to avoid "the call" in the first place.

- Each office should appoint an individual (can be the doctor) who reviews random records on a pre-determined regimen. Set guidelines, objectives and specific office protocols of how these self audits are to be completed and maintain this in your office's compliance manual.

Practice Profitability

How to keep your **compliant** practice profitable!

Coding Strategies

- What procedures are being done that you're not being paid for?
- Are there procedures, services or products that the doctor wants to add?
- Review new contract fee schedules to make sure you're using them to your advantage.
- Develop an EASY way for the doctor to communicate procedures to the staff.
- Review EOB's to find unpaid codes, underpaid codes, etc.
  - Does the doctor review EOB's regularly????

What coding are you missing?

- Use the correct E/M codes
- Bill for **ALL** re-exams (any new injury)
- Code all therapies… ie: ice
- Use higher level 989- codes when performed
- Bill for extremity adjusting
- Use rehab codes ie: 97530, 97110, etc.
- Taping, ADL's, supplies, orthotics, reports, etc.
- DME???

The "MOST" Important Coding Strategies

- Bill for all the services you provide but only bill for the medically necessary things that you do.
  - 98940's
  - 1,2,3 PT's *not everyone needs it*…
  - Use appropriate E/M coding levels
  - Clinically appropriate use of codes ie: don't up-code everything or use a "cookie cutter"
  - Frequency of care? Does it vary?
  - Age appropriate care
  - CASH visit…. Most important fee

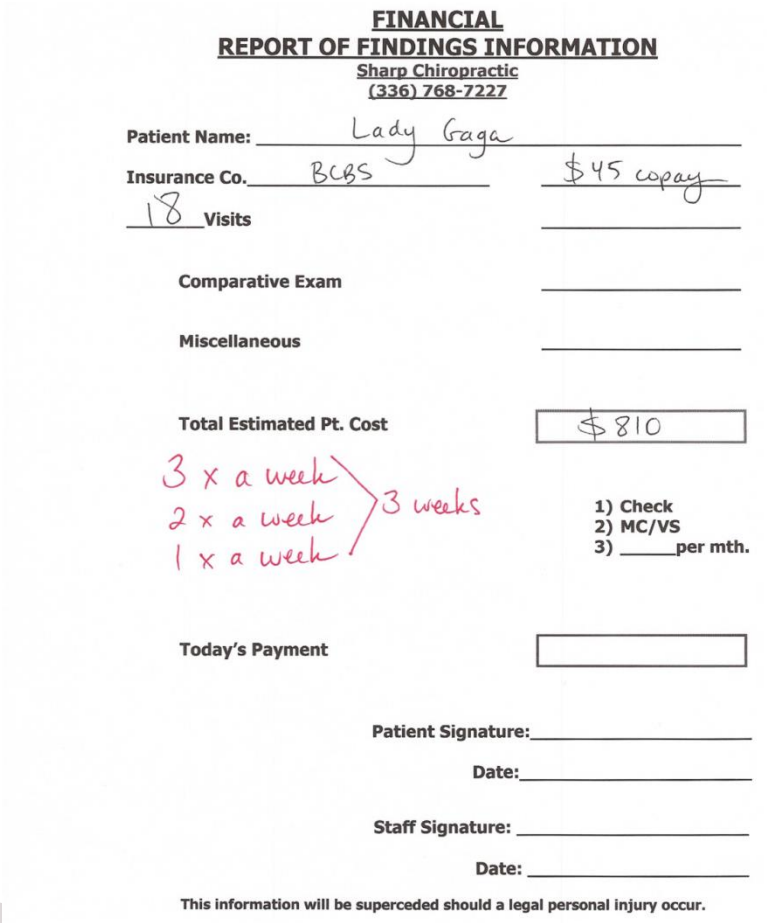
The Financial ROF…

Closing the deal doesn't have to be such a big deal!

The Essentials of the Financial ROF

1- Don't talk too much!
2- It needs to be preceded by a "great" clinical ROF
3- You need to have the belief and conviction that the doctors care is necessary
4- Above all things, be HONEST with the patient
5- Follow your script every single time
6- Honesty is ALWAYS the best policy
7- Don't talk too much!

Our “not so fancy” financial ROF



FINANCIAL
REPORT OF FINDINGS INFORMATION
Sharp Chiropractic
(336) 768-7227

Patient Name: Lady Gaga

Insurance Co. BCBS — $45 copay

18 Visits

Comparative Exam

Miscellaneous

Total Estimated Pt. Cost $810

3 x a week
2 x a week
1 x a week
} 3 weeks

1) Check
2) MC/VS
3) _____per mth.

Today’s Payment

Patient Signature:_____

Date:_____

Staff Signature: _____

Date: _____

This information will be superceded should a legal personal injury occur.

High deductible plans and how to manage them.

- Above all, be honest with your patients and tell them the true cost of their care.
- Bill for ALL of your services and collect that money based on the alloweds.
- Don't automatically turn them into "cash" patients.
- Simply make this part of your financial ROF.

- This is one of the most important profitability issues in Chiropractic right now and many of you are committing fraud by the way you are handling this.

HOW DO WE GROW OUR PRACTICES?

- Where can we grow our profit?
- What fees do we need to look at?
- What services do our patients ask us to provide?
- Stop discounting fees, not charging for all of your services and bill those high deductible plans.
- Review your fees regularly including your CASH fee.

Strategies for YOUR Office!

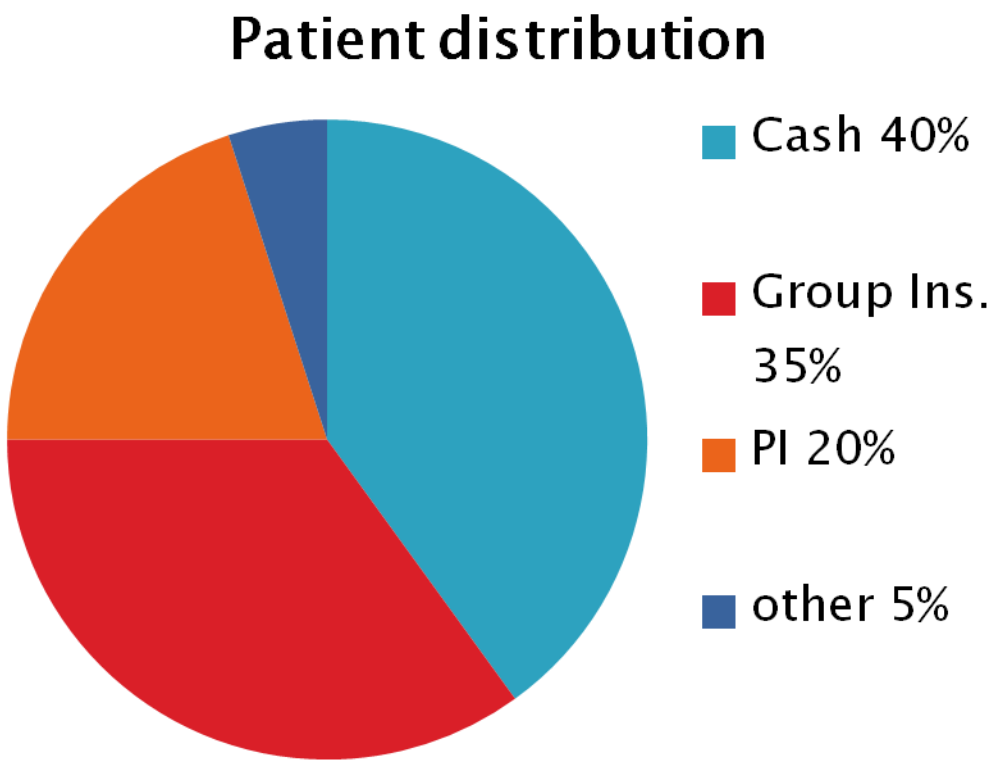
Action steps……
"Flow, technology, communication"

Practice Objectives

- Do we need to update our forms?
- How are we going to collect money from our patients?
- Do we need to add any technology to our practice?
- How can we better communicate without talking as a staff?
- What services do we need to start adding?
- How can we make our system smooth and with less ***STRESS?***

Let’s take a closer look at where you’re missing out.

The bottom line…



The Art of Developing Maintenance Patients

It doesn't happen by accident…

When it all begins… setting the stage for longterm care

- **Maintenance patients begin at the ROF**
  - Do they have lifelong spinal issues?
- **Table talk as they progress**
  - Reminders of their progress and what it took to get better.
- **Educate at the progress examination**
  - Clinical outcome assessment forms
- **More table talk to keep them informed**
  - Weekly reminders
- **Wrapping it all together at the end of "active treatment".**
  - They should already know by this time!
- **Let's not forget where those Maintenance patients come from. Insurance contracts give access to patients!**

How it Flows in my Office!

Closing thoughts….

There is a professional and personal responsibility for each individual Chiropractor to take their documentation, practice administration and patient care to a higher consciousness and level of competency. This “cultural obligation” will either be determined by Chiropractors or by the payors. That cultural authority is now in our court but ultimately will not if we don’t move forward quickly.

Dr. Kevin Sharp