## About Dr. Mario Fucinari, DC, CCSP, MCS-P

Graduate of Palmer College of Chiropractic - 1986
Certified Chiropractic Sports Physician (CCSP) – Logan College of Chiropractic
Certified Insurance Consultant - Logan College of Chiropractic
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National Speaker's Bureau for NCMIC and Foot Levelers and many state associations
Faculty and Post-graduate Faculty of Logan College of Chiropractic
President of Illinois Chiropractic Society (ICS) and Chairman, ICS Medicare Committee
Member of ACA, FCER & ICS
Member of the American Academy of Professional Coders
Contributing Author to many State Association Newsletters

## Risk Management
## Why documentation?

- To reduce and prevent the possibility of malpractice actions
- To ensure better patient care and reduced stress in the practice with better communication with other health care professionals
- Ease of payment in managed care, private health insurance and in pre-certification of services.
- Collection of data for research and education.

### Standard of Care

Standard of Care is defined as "that course of action that a reasonably prudent [physician] in the defendant's specialty would have taken under the same or similar circumstances."
*-Washington v. Washington Hospital Center*
*579 A2d 177 (DC App 1990)*

Standard of Care is the benchmark used to evaluate and guide the practice of medicine encompassing the learning, skill and clinical judgment ordinarily possessed and used by providers of good standing in similar circumstances

Documentation is the Language We Speak

"In the area of health, chiropractors begin with a different set of assumptions, use different theoretical explanations, embrace a different philosophy, pose different questions and use different language and different therapeutic solutions than medicine."
Coulter, ID. *The Chiropractic Paradigm*, JMPT, 1990; 13: 279-287.

- Prior Surgery Type, date, reason, results, current status
- Prior trauma
    - Type, date, treatment, current status and extent of impairment
    - The most common mistake is not going back far enough when questioning about trauma or injury.
- Social History
- Marital status
- Employment history
- Occupational history
- Use of drugs, alcohol, tobacco
- Level of education
- Sexual history and social factors

Review of Systems: 99203 3-8/13
Ophthalmologic, Otolaryngologic, Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Skin, Neurologic, Psychiatric, Endocrine, Hematologic/Lymphatic, Allergic/Immunologic

## The Consultation
## O,P,Q,R,S,T

Mechanism of Trauma
**O**nset, duration, intensity, frequency, location and radiation
**P**rovoking and Palliative Factors
**P**rior interventions, treatments, medications, secondary complaints
The Consultation
**Q**uality and character of symptoms/problem
**R**adiation of symptoms
**S**everity
**T**ime

**Non-Pregnancy Verification**
Get it in writing
Have witness countersign (not initials)
LMP – when was last menstrual period?
Required prior to X-ray and therapy

**Treatment of a Minor**
Have permission slip signed by the parent/guardian prior to treatment.
Remember, you are a "Point of Contact" for abuse or neglect observance.
*Anytime abuse or neglect* is suspected, you must report it to DCFS

A parent has the right to obtain child's health information except when…
1. State law does not require parental consent.
2. Guardian is appointed by the court.
3. When the parent agrees to the confidential relationship.
4. When the provider suspects abuse or neglect.

**Informed Consent**

**www.ncmic.com/3806**

**Informed Consent**
Prior to treating a patient, the doctor must provide adequate information concerning the possible risks, benefits and alternatives to a particular procedure. Doctors must properly and clearly communicate with their patients. If called into question, documentation of the communication is vital.

- A general informed consent is recommended.
- Describe the procedures to be employed.
- Disclose the risks of treatment
- Inherent – foreseeable
- Answer any questions for the patient

Informed Consent
The patient underwent their report of findings today. The patient indicated an understanding of the findings and recommendations. All questions were answered for the patient. The patient voiced approval of the recommendations. Treatment today consisted of CMT-Div. to C7, T3, T12 and L5, IF and ice to C7 and L5 to decrease pain, spasms and edema. The patient tolerated the procedure without incident. Treatment goals are to decrease pain, spasms and edema in the next four weeks. Home care consisting of Cox 1-5 stretching exercises, cervical stretches and ice q3-4h X 48h.
John Smith DC

## The Basics of a S.O.A.P. Note
## *(The language we speak)*

General Questions
**Subjective – What's going on? ♪♫♪**

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

 

Chief Complaint
CPT Guides: Chief complaint is a "concise statement describing the symptom, condition, diagnosis, and/or other factors that are the reason for the encounter, usually stated in the patient's own words." Must be clearly documented in a patient's record.

Example of Subjective – Narrative Version
S: The patient still complains of moderate pain in the left shoulder to the hand. She stated that her neck pain is sore and stiff. Pain is reported to be increased when looking up for prolonged periods of time. She stated that she was spring cleaning her closet two days ago, afterward she had increased pain.

General Components of the O (Objective)
**Objective – What did you find?**

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

## Evaluation and Management (E/M) Codes

Seven Components of the E/M service
Key Components

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

Contributing Components

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

**The Physical Exam**

- The E/M code level of the examination should be appropriate for the condition and differential diagnosis.
- You must, at a minimum, examine the area of chief complaint.
- Examine all areas which will undergo chiropractic adjustment.
- Examine area to which the chief complaint refers pain.
- E/M CPT codes used are based the level of service.

**New patient vs. Established patient**
New patient is a patient never treated in the office or not in the last three years. The same degree of familiarity is applied for a doctor who is on call for you.

New Patient codes: 99201-99205
Established Patient Codes: 99211-99215

Considerations for 99201/99211
99211 no physician is required to be present.

CPT describes 99211 as follows: The Nurse Code
"Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services."

Considerations for 99205/99215
99205/99215 comprehensive examination
Each of the systems examined must be listed to be considered as part of the exam. If there are no pertinent findings, then you must indicate it by "all other systems are negative."

99203 should include findings from 3-8 body areas or organ systems.
BODY AREAS: Head, Neck, Chest, Abdomen, Genitalia, Groin, Buttocks, Back (including spine), each extremity
ORGAN SYSTEMS: Ophthalmologic, Otolaryngologic, Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Skin, Neurologic, Psychiatric, Endocrine, Hematologic/Lymphatic, Allergic/Immunologic

On the initial examination or if significant, on subsequent visits, note the following:
- Inspection
- Patient build
- Carriage and gait cycle
- Patient movement
- Examine the shoes
- Scoliosis
- Antalgia
- Skin appearance
- Biomechanical Inspection
- Vital signs
- Height
- Weight
- Temperature
- Respiration
- Pulse bilaterally (rapid?)
- Blood pressure bilaterally

*Spinal Manipulation and Cervical Arterial Incidents* (NCMIC, Chapter 8, page 48)
"In contrast to earlier clinical practice recommendations, auscultation of the neck[108;176;239;343-352] and use of functional vascular test variations (e.g., Estridge's, deKleyn's, George's, Hautant's, Houle's, Maigne's, Smith's, Wallenberg's tests, etc.)[4] now are known to have no diagnostic value in identifying patients with cervical vascular susceptibility."

Palpation
- Static
- Musculature spasm
- Edema
- Tenderness on palpation
- Motion
- Segmental motion
- List any crepitus

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

**Orthopedic Test Nuances:**
Decreased muscle strength -
Straight Leg Raise -
Kemp's -
Yeoman's -
Valsalva -
Cervical compression -

Check the Shoes:
- Size
- Ball Fit
- Shape
- Last
- Toe Box
- Vamp
- Heel Counter
- Support
- Shank

**Inspection of the feet:**
Nail Beds
Pes Planus (734)
Morton's Metatarsalgia (Neuroma) 335.6
Hallux Valgus (Bunion) 735.0, 727.1
Bunionette (Tailor's Bunion) 727.1
Hammer Toes 735.4
Claw Toes 735.5
Mallet Toes
Haglund's Deformity (Pump Bump) 726.91

Biomechanical Inspection of the feet – Objective findings

**E/M codes and Place of Service Codes**
New Patient office E/M codes (11): 99201-99205
Established Patient office E/M codes: 99211-99215
Hospital (Inpatient) (21): 99221 – 99239
Home Services (12): 99341 – 99350
Nursing Facility (31 or 32): 99304 – 99318

Example of the Objective - Narrative version
O: Decreased joint motion at C4, C7 and T2. Patient holds head in a 10 degree right lateral antalgia. AROM is decreased on flexion (-10 degrees), extension (-35 degrees) and left rotation (-50 degrees). Cervical compression, foraminal compression and maximal cervical rotation is positive on the left for C7-T1 pain non-radiating. Moderate spasms palpated in the left posterolateral cervical muscles. Tenderness to palpation is in the C4-C7 region paracervical muscles bilaterally.

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

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

 

**Outcome Assessment Tests**

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

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

Outcome Assessment Tests - to be significant, the assessment test must have a minimum of a 30% change in score to be clinically significant.

**Re-Examination**

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

A re-examination should include

- A brief consultation about current condition
- Repeat of significant orthopedic tests
- Visual Analog Scale or Borg Scale
- Outcome measures test repeated

After the re-examination, update record with an interim note or report:

Re-examination documentation note:
The patient underwent a re-examination of the cervical spine to determine her progress and need for further care. At this time the patient reports...

Re-exam is done. Now what?

- Treatment plan needs to change.
- If the patient is improving the following needs to happen:
- Fewer weekly visits
- Fewer modalities
- Move toward active care rather than passive

If the patient has NOT made significant improvement, the following needs to happen:

- A change in the treatment
- A referral for a second opinion to another DC, MD or DO
- Or a referral for advanced testing such as CT, MRI or EMG

## RADIOLOGY

### Quality

Is the billing of poor quality x-rays fraud?

Factors affecting X-ray quality

- Processor clean?
- Chemistry
- Light leaks
- Technique chart
- Lack of filters
- Screen-film mismatch
- Patient positioning

Identification Information on the X-Ray

- Complete patient name
- Clinic or Doctor's name
- Address location of clinic
- Date of Service
- Age of Patient

Clinical Indications For Plain Films
Differential Diagnosis from the history and physical examination.

To rule out:

- Degenerative conditions
- Inflammatory conditions
- Fracture
- Neoplasms
- Infection

Clinical Indications for MRI or CT

- Non-responsive, deteriorating or lingering symptoms after 4 weeks

Radiology Red Flags

- X-rays that are outside of the area of chief complaint.
- Full spine x-ray for trauma case or on everyone.
- Unbundling of x-rays
- Repeat studies
- Repeating films recently taken at another facility.

Radiology Reports

- The standard of care is that all radiographic studies are performed to reach a diagnostic conclusion.
- A written, usually typed, interpretation of the study is included as part of the patient's permanent record.
- Reports are signed and dated by the individual performing the interpretation.
- Radiology Reports
- Checklists are not considered appropriate.
- Checklists confine your interpretive eye and therefore, findings may be missed.

Radiology Malpractice

- If you read your own films, you are held to the same standards as a radiologist.
- When you perform the service of a radiologist, you accept the level of liability that is attached to that service.

General Components of the A (Assessment)

**Assessment – What do you think?**

- Provider records their professional opinions and judgments as to the patient's diagnosis, their progress and/or their functional limitations.
- You interpret the data presented in the objective portion of the note.
- You may also point out inconsistencies, justify your goals, discuss emotional status or indicate progress in therapy.
- You may also present reasons why certain information was not obtained or deferred.
- Recommendation of further tests or treatment that you think is necessary.
- Recommendation of referral to another provider.
- Do not introduce new data here.
- This is the area where you record *your* thought processes and concerns.

General Components of the A (Assessment) cont'd

- Assessment is the heart of your note. Merely putting "The patient is improved" does not justify your treatment or your education.
- This is the section that justifies your clinical reasoning as a chiropractor.
- Be data driven. An insurance adjuster must be able to see what you see.
- Your assessment must use measurements, co-morbidity factors, test results and unusual circumstances to explain what is happening in the case.

- One very useful way of justifying continued chiropractic care is to end the "A" with the statement "Patient would benefit from..."
- This may also be contained in the plan instead.
- Diagnostic Tests are used to rule out pathology and improve outcomes.

- Writing the Diagnosis
- Change the diagnosis, if needed, in such a way that clearly documents the patient's progress (or lack thereof).
- Write Dx in the notes as well on the claim form

- Update your prognosis, change in treatment and anticipated duration of treatment.
- Tell why the patient still needs treatment.
- ICD-9 codes should reflect why certain services are done. (e.g. 719.51 shoulder stiffness)

**Coding Tools for Reimbursement**

Healthcare Common Procedure Coding System (HCPCS)

- HCPCS Level I = Current Procedural Terminology (CPT)
- HCPCS Level II = National Codes

Current Procedural Terminology (CPT)

- Owned and maintained by AMA since 1966
- Five Digit XXX.XX

HCPCS Level II

- Owned and maintained by CMS since 1983
- Letter followed by four digits LXXXX
- Products, supplies, services
- Ambulance
- Prosthetics
- Medical supplies

**1500 Health Claim Form**

1500 Health Claim Form is the uniform, standardized form to be used by providers. Computer generated forms or typed forms are processed more quickly than handwritten forms.

"Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. Under penalty of perjury, I declare that I have read the foregoing; that the facts alleged are true, to the best of my knowledge and belief; and that the treatment and services rendered were reasonable and necessary with respect to the bodily injury sustained."

False Claims Act "Lincoln Law" Amended in 1986

"Any person who knowingly presents or causes to be presented, to an officer or employee of the U.S. Government or the Armed Forces of the U.S., a false or fraudulent claim for payment or approval...is liable to the U.S. Government for a civil penalty of not less than $5,000 and not more than $10,000 plus three times the amount of damages."

False Claims Act "Lincoln Law"

- Knowingly presenting a false claim
- Knowingly using or causing to be used a false record or statement to get a claim paid.
- Conspiring with others to get a claim paid.

- Knowingly using or causing to be used a false record or statement to conceal, avoid, or decrease an obligation to pay money to the Federal Government.
  - It is not necessary for the government to prove intent to defraud.

**Writing the Diagnosis**
There are four diagnostic codes allowed on the 1500 form however, you can list additional diagnostic descriptors in your diagnosis list in the patients chart.

Hierarchy of the codes:
1. Neurological diagnosis
2. Structural descriptor diagnosis
3. Functional diagnosis
4. Soft tissue, extremity, complicating factors

Writing the Diagnosis:
- Neurological diagnosis include radiculitis and sciatic neuritis
- Structural diagnosis includes DDD, DJD and spondylolisthesis
- Functional diagnosis includes restricted range of motion and deconditioning syndrome (useful for rehab)
- Soft tissue diagnosis may include fibromyalgia
- Extremity diagnosis includes carpal tunnel syndrome or adhesive capsulitis

**Neurologic Diagnosis Examples**
Lumbar
722.10 Lumbar disc herniation
724.3 Sciatica
722.83 Lumbar postlaminectomy syndrome

Cervical
353.0 Brachial plexus lesion (TOS)
722.0 Cervical disc herniation
723.4 Cervical neuritis
722.81 Cervical postlaminectomy syndrome

**Structural Diagnosis Examples**
Lumbar
722.52 Lumbar degenerative disc disease (DDD)
738.4 Spondylolisthesis
724.02 Lumbar spinal stenosis
Cervical
721.0 Cervical spondylosis w/o myelopathy
722.4 Cervical degenerative disc disease
737.10 Cervical kyphosis
722.81 Cervical postlaminectomy syndrome

**Structural Diagnosis Examples**
Limb Length Discrepancy 736.81, 755.30
Haglund's deformity "pump bump" 726.91
Hammer toes 735.4, 755.66
Plantar fascitis 728.71
Tarsal Tunnel Syndrome 355.5
Tailor's Bunion 727.1
Pes Planus 734
Metartarsalgia 726.70
Morton's Neuroma 355.6
Calcaneal Spur 726.73
Hallux Rigidis 735.2

**Functional Diagnosis Examples**
Lumbar
719.75 Difficulty in walking
728.2 Disuse atrophy/Deconditioning
733.02 Osteoporosis, idiopathic

Cervical
718.4 Contracture of joint
719.5 Stiffness of joint
728.2 Disuse atrophy/deconditioning
737.9 Curvature of the spine, unspecified (hunchback, acquired)

Deconditioning Syndrome (728.2)
"Diminished ability or perceived ability to perform tasks involved in a person's usual activities of daily living."
Rehabilitation of the Spine by Craig Liebenson. Pg. 7

**Soft Tissue Diagnosis Examples**
Lumbar and Cervical
728.85 Spasms of muscle
782.3 Edema
729.1 Myositis
729.4 Fascitis, unspecified

**Complicating Factors**
Return to pre-episode status for an **uncomplicated** case is listed as 6 to 8 weeks with up to 3 treatments per week.

Complicating Factors:
Symptoms present for more than 8 days = 1.5X Longer
Number of previous episodes is 4 to 7 = 2X Longer
Presence of skeletal anomaly is 1.5 X longer. Structural pathology increases recovery by 2X Longer

**Daily Therapy Record** Documentation Necessary

- Date
- Modality used
- Area treated
- Therapy settings
- Treatment time
- Recommended home care
- Patient response
- Initials of therapist
- Rationale for treatment

**Content of the Physical Therapy Plan**

The Plan must describe the following:

- The type of therapy to be performed
- The amount/settings
- The frequency of treatments
- Duration of the treatment
- The region/location to be treated
- The diagnosis
- The anticipated goals

Physiotherapy

Passive modalities imply that the patient is passive in the encounter. (Acute care)

Supervised Modalities

| | |
|---|---|
| 97010 | Heat, ice |
| 97012 | Mech Traction |
| 97014 | Electric Stim |
| 97016 | Vasopneumatic Devices |
| 97018 | Paraffin Bath |
| 97022 | Whirlpool |
| 97024 | Diathermy |
| 97026 | Infrared |

Passive modalities used in acute care.

- Acute intervention
- Promote anatomical rest
- Diminish Muscle Spasm
- Reduce inflammation
- Reduce Pain

Passive modalities imply that the patient is *passive* in the encounter.

Constant Attendance Modalities (Acute to Sub-acute care)
97032 Electric Stim (attended)
97034 Contrast Baths
97035 Ultrasound
97036 Hubbard Tank
97020 Microwave has been deleted and combined with 97024 Diathermy

Red Flags in Therapy

- Using modalities with similar therapeutic effects on the same day such as e-stim, diathermy and heat
- Using therapies after reaching their maximum therapeutic effects (10-15 applications)
- No rationale in the daily note

Active modalities imply that the patient is *active* in the encounter.

- Direct one-on-one patient contact
- Billed in 15-minute unit of time

Rehabilitation Therapy

- Purpose is to identify the cause of the pain, reduce the cause and teach the patient how to keep the problem from returning.
- The goal of rehabilitation is to reduce the patient's painful intolerances.
- Perform functional capacity evaluation as soon as the patient is out of acute pain phase of care.
- Goal of care transitions from pain relief to functional restoration.
- Every rehabilitation program must start with an assessment of abnormal function (strength, endurance, coordination, balance and flexibility)
- The functional deficit is the baseline from which to determine progress
- Why are you doing that particular exercise?
- Ask the patient, "What can you NOT do?"
- The history for rehabilitation documentation should identify what activity intolerances are present.
- The rehabilitation care must identify the **"patient-centered"** goals of care.
- **Restoring those functions becomes the main goal or end point of care.

Rehabilitation Therapy

- Remobilization
- Increase pain free AROM
- Minimize deconditioning
- Restore strength and/or endurance
- Increase physical work capacity
- Lifestyle Adaptations
- Modify social and recreational activities
- Diminish work environment risk factors
- Adapt psychosocial factors affecting or altered by the spinal disorder

particular group setting, the number of persons in the group and the treatment goal in the individualized plan.
- Time is not defined in this code.
- Bill CPT 97150 to each patient, not the service code.
- Do not use 97112 and 97150 together.

**97124 Massage**
- Passive modality used when treatment goals are to increase circulation, restore muscular integrity, reduce edema, improve joint motion and for relief of muscle spasm and soreness.
- For friction massage, effleurage, petrissage and tapotement
- DO NOT USE 97124 and 97140 on the same day.

**97140 Manual Therapy (Hands-On)**
- Used for soft tissue and **joint mobilization**, manual muscle work (not AK), myofascial release, connective tissue massage and **trigger point therapy**.
- When billed together with CMT, manual therapy must be in a separate body region.
- Document goals, procedure used, time of treatment and area of treatment.
- Diagnosis must be linked on the CMS-1500 form.
- DO NOT USE 97124 and 97140 on the same day.

**97140 Joint Mobilization**
- Treatment goal is to decrease pain and increase joint mobility
- Note where the range pain was felt and where the resistance was present
- Compare involved extremity to uninvolved
- Document level of pain and ROM before and after the treatment
- Document amount of treatment time
- Grade IV of Maitland's Grades of Mobilization (Grade V is manipulation).

**Diagnosis Pointing**
- Diagnosis goes in Box 21 of the CMS-1500 form.
- Relate the items listed on 1,2,3 or 4 in Box 21 to the services performed. These are linked in Box 24 E
- Especially useful in Manual Therapy (97140) and Therapeutic Exercises (97110)

CPT Coding
You are required on a visit-by-visit basis, to determine what was medically necessary for manipulative procedures on that particular day. This must be documented to correspond with the symptoms, diagnosis and treatment goals. Some doctors use the manipulation code 98940 on every patient, while still others may use the 98942 code every visit. Neither of these is appropriate in *all* cases. In fact, this is considered a red flag.

Manipulation/Adjustment Coding
98940 – 1-2 Spinal Regions
98941 – 3-4 Spinal Regions
98942 – 5-6 Spinal Regions
98943 – Extraspinal, one or more regions
Head including TMJ, excludes atlanto-occipital
Upper and lower extremities
Rib cage (excluding costotransverse and costovertebral)
Abdomen

Coding The CMT
Full Spine Adjustment: The treating doctor should prioritize the level of adjustment and code for the primary area(s) of concern.
98940: 40%
98941: 45%
98942: 15%

98943 Extraspinal CMT, with spinal CMT no longer requires a 51 modifier

**Treatment Plan**
**What are you going to do about it?**

**Your plan should indicate:**
- Adjusting procedures to be used
- Treatment schedule frequency
- Which modalities and why
- Therapeutic exercises, frequency and goals
- Restrictions and TTD. Indicate time expiration if applicable
- Treatment Plan
- Home care recommended
- Braces, supports and pillows prescribed and rationale for them
- Nutritional recommendations such as dietary recommendations and nutritional supplementation.
- Referrals or further tests to be ordered
- Explained procedures, risks and alternatives

Writing the P - Plan
- Set-up or establish the treatment goals.
- Treatment rendered during the visit.
- Tie in the treatment with the assessment and treatment goals.
- As an example, why was ultrasound used?
- Record the segments adjusted and technique used in the adjustment.
- "Patient tolerated procedure without incident."

Supportive/Adjunctive/Ancillary Care

- Indicate which modalities will be used
- State the clinical reasons for their use

Sample Explanation of Services

- Mechanical traction (97012) to increase joint range of motion and restore ligament elasticity and to reduce adhesions.
- Electrical muscle stimulation (97014 or 97032) to decrease muscle spasm, increase mobility and restore muscle tone.
- Ultrasound (97035) to reduce inflammation, locally sedate the area and to increase circulation to decrease muscle congestion and spasms.
- Diathermy (97024) to provide analgesia, relieve muscle spasms, increase circulation and reduce inflammation.

Prognosis

A prediction of the level of improvement and the amount of time needed to reach that level. Indicate any factors that will influence the prognosis such as employment, living conditions and pre-existing conditions.

Prognosis

The prognosis of this patient is considered poor, due to the degree of degenerative disc disease. Treatment will consist of specific spinal manipulation to the L5 and SI joints, appropriate adjunctive therapy and instructions for lumbar stretching exercises to be done at home. Treatment goals are to decrease pain, spasms and edema and to increase lumbar range of motion within the next four weeks. The patient is expected to be initially under care for approximately 4 weeks followed by a re-examination. Treatment toward MMI is expected to take up to four months. Treatment plan will initially be 3 times per week for 3 weeks, then 2 times per week for one week, followed by a re-examination.

Signatures/Initials

- If you are the sole practitioner (licensed professional) in your office, it can be assumed you performed the service. You may wish to initial all entries.
- If there are multiple providers, the provider must be clearly identified in the office notes.
- A log of all provider's and staff's signatures is recommended for identification.
- All entries in the record should be dated, timed if necessary and authenticated by signature or initials.
- An electronic signature is acceptable as long as it is personally attached to the electronic medical record.
- The electronic signature should be password protected.

 

## Initial Visit Report

The following documentation requirements apply whether the subluxation is determined by x-ray or by physical examination:

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

**III. Physical Examination**

Evaluation of the musculoskeletal/nervous system

**IV. Diagnosis**

1. Subluxation (not needed on demo claim)
2. Secondary Dx.
3. Complicating Factors

Description of present illness

- Mechanism of trauma
- Quality and character of symptoms/problem
- Symptoms *MUST* have a direct relationship to the spine either by vertebral pain, muscle pain, bone pain, rib pain or joint pain or inflammation.
- A symptom of pain is not enough. The location of pain must be listed and the vertebra, which is in relationship to it, must be included.
- Must be musculoskeletal in nature.
- Onset, duration, intensity, frequency, location, radiation of symptoms
- Provoking or palliative factors

**V. Treatment Plan**

- Recommended Level of Care (duration and frequency of visits)
- Specific Treatment Goals
- Objective measures to evaluate treatment effectiveness

**VI. Date of Initial Treatment** (Box 14)

Daily SOAP

**I. History**

- Review of chief complaints (is this in relationship to the initial visit or treatment for the exacerbation)
- Changes since last visit
- System review if relevant

**II. Physical Exam**

- Exam of area involved in Dx..
- Assessment of change in patient condition since last visit
- Evaluation of treatment effectiveness

**III. Evaluation of treatment effectiveness**

Effectiveness (Assessment)with regards to the recommended level of care, duration, frequency and goals that were developed at the initial visit or at the time of the exacerbation.

**IV. Documentation of treatment given on day of visit**

## P.A.R.T.

To demonstrate a subluxation of the spine 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.

P.A.R.T.
(2 of the 4 Required)
1. Pain/Tenderness - location, quality, intensity
Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation, provocation, etc. Furthermore pain intensity may be assessed using one or more of the following: visual analog scales, algometers, pain questionnaires, etc.
P.A.R.T.

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

**3. Range of Motion Abnormality**
Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and Range of motion abnormality

Range of motion abnormalities may be identified through one or more of the following: motion palpation, observation, stress diagnostic imaging, range of motion measurements, etc.

**4. Tissue,** tone changes in skin, fascia, muscle, ligament
Tissue, tone changes using descriptions pertaining to the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament. Tissue/Tone

texture may be identified through one or more of the following procedures: observation, palpation, use of instruments, tests for length and strength etc.

Reasonable and Necessary Care
1. The care must not be experimental or investigational
2. The care must be safe and effective
3. The care must be appropriate
   - Time, duration and frequency (freq. is a red flag)
   - Meet accepted standards
   - Be conducted in an appropriate setting
   - Performed by qualified personnel
   - Meet the patient's needs (and not exceed them).
   - Be beneficial as available alternatives

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

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

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

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

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

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

Defined as: A treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition. Once the maximum therapeutic benefit has been achieved for a given condition, ongoing maintenance therapy is not considered to be medically necessary under the Medicare program.