CHART AUDITING WORKSHOP

UVCA FALL CONVENTION 2024

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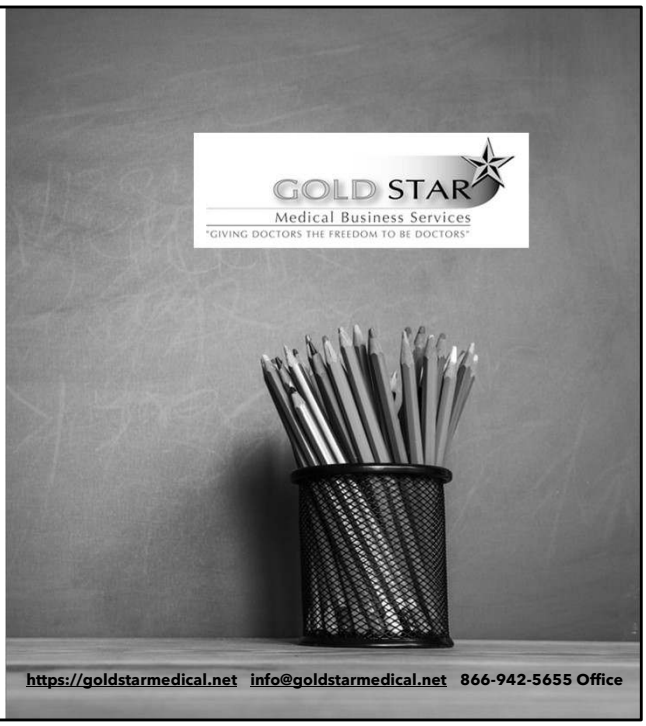

GOLD STAR
Medical Business Services
"GIVING DOCTORS THE FREEDOM TO BE DOCTORS"

LISA MACIEJEWSKI-WEST: CMC, CMOM, CMIS CPMA-I, CPCO-I

- Owner/Founder Gold Star Medical Business Services
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- Member Chiropractic Future Strategic Plan Technical and Reimbursement Committees
- Member TX Chiropractic Association Insurance Reimbursement Committee

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The antitrust laws seek to preserve a free competitive economy and trade in the United States and in commerce with foreign countries. Competitors may not restrain competition among themselves with reference to the price, the quality or the distribution and outputs of their products, and they may not act in concert to restrict the competitive capabilities or opportunities of their competitors, their suppliers or their customers.

Since you have an important responsibility in ensuring antitrust compliance in your healthcare activities, you should comply with the following guidelines:

Don't discuss with other providers your own or competitors' prices, or anything that might affect prices such as costs, discounts, terms of sale, or profit margins.

2. Don't make public announcements or statements about your own prices or those of competitors.
3. Don't make derogatory statements relating to the incompetence, fees or policies of insurance companies or companies providing ancillary services
4. Don't threaten or recommend an embargo of a certain company. This includes statements relating to recommendation of withdrawing from certain insurance plans
5. Don't stay present where any of the above discussions are taking place.
6. Remember that meetings with government officials may not provide a shield against antitrust liability.
7. Remember that the antitrust guidelines apply to all communications, whether in person, by telephone, email, or any other means.
8. **Confer with counsel before bringing up any topic or making any statement which may implicate any of the above guidelines, or which may otherwise have competitive ramifications.**

The United States Sentencing Guidelines for Organizations is a federal law pertaining to the assessment of damages in cases of fraud against the government. The Guidelines list seven essential requirements of an effective compliance program.

COMPLIANCE 101

1.Implementing written policies and procedures

2.Designating a compliance officer and compliance committee

3.Conducting effective training and education

4.Developing effective lines of communication

5.Conducting internal monitoring and auditing

6.Enforcing standards through well-publicized disciplinary guidelines

7.Responding promptly to detected problems and undertaking corrective action

Conducting internal monitoring and auditing

"It is recommended that an individual(s) in the physician practice be charged with the responsibility of periodically reviewing the practice's standards and procedures to determine if they are current and complete. If the standards and procedures are found to be ineffective or outdated, they should be updated to reflect changes in Government regulations or compendiums generally relied upon by physicians and insurers"

Federal Register / Vol. 65, No. 194 / Thursday, October 5, 2000 / Notices

DOCUMENTATION MYTHS

- There is a different standard of documentation if the patient pays cash
- There is a different standard of documentation if I'm Out of Network
- I can submit claims before I've completed my notes, and finish them at a later time
- I can leave my notes unsigned in case I need to make changes or updates

DOCUMENTATION MYTHS

If I learn the Medicare documentation standard, it will work for all payers

If I under-code, I won't be audited (billing 98940 on all claims)

WHY THE INCREASE IN AUDITS? HEALTHCARE EXPENDITURES ON THE RISE

SOURCE:
https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet

Table 7

Physician and Clinical Services Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2016-2032

Year	Total	Out-of-Pocket Payments	Total	Private Health Insurance	Medicare	Medicaid	Other Health Insurance Programs[2]	Other Third Party Payers[3]
Historical Estimates		Amount in Billions						
2016	**$676.**	**$58.1**	**$541.2**	**$283.6**	**$154.5**	$73.1	$30.1	$77.3
2017	709.	59.6	568.	297.8	164.1	74.9	31.8	81.2
2018	736.	60.8	592.	300.9	178.1	78.4	34.6	83.4
2019	767.	61.9	620.	304.1	194.3	83.9	38.4	85.3
2020	818.	60.0	629.	305.7	194.0	87.3	42.7	128.8
2021	861.	65.8	688.	326.8	219.2	99.3	43.6	107.1
2022	884.	67.3	731.	342.0	234.1	110.1	45.4	86.0
Projected								
2023	959.	71.5	792.	372.1	254.2	116.0	50.5	94.8
2024	**$ 1,006.5**	**$ 75.70**	**$ 829.70**	**$400.00**	**$ 265.70**	110.4	53.6	101.2
2025	1,055.	78.6	870.	417.0	283.1	114.3	56.5	105.8
2026	1,105.	82.2	911.	425.0	305.5	121.8	59.6	110.9
2027	1,171.	86.1	969.	445.2	331.9	129.2	62.8	116.0
2028	1,230.	89.6	1,020.	463.5	354.3	136.2	66.1	121.0
2029	1,302.	93.3	1,083.	482.5	387.4	144.1	69.5	126.1
2030	1,371.	97.0	1,143.	501.7	416.4	152.5	73.1	131.2
2031	1,445.	101.0	1,207.	522.0	447.1	161.3	77.0	136.7
2032	**$ 1,522.1**	**$ 104.70**	**$ 1,275.20**	**$541.70**	**$ 481.50**	170.9	81.0	142.2

AUDITS ON THE RISE

- *1980 Less than 3% of all claims were audited
- *1990 13% of claims are audited
- *2010 22% of claims are audited
- **2024 100% of claims are audited**

*SOURCE: https://www.bea.gov/index.php/system/files/papers/WP2015-4.pdf (Bureau of Economic Analysis)

100% of Claims are Audited
PRE PAYMENT AUDITS

- ✓ Automated: In your software (edits and templates)
- ✓ Automated: At your clearinghouse (Smart Edits, NCCI Edits)
- ✓ Automated: At the payer level (NCCI Edits, Subscriber Information, Payer Policy Edits)
- ✓ Manually: Your coder/biller/billing team (Provider Queries)
- ✓ Manually: The Payer. Claims may be "pulled" from the Automated System for a more in-depth look by a claims adjuster. (Records Requests)

100% of Claims are Audited
POST PAYMENT AUDITS

- ✓ Automated: Random/Lottery
- ✓ Automated: Based on Historical Data derived from data mining programs
- ✓ Automated: Based on Provider Type (OIG Workplan, CERT Audits)
- ✓ Manually: Based on Individual/Provider Error rates and trends
  - ✓ Claims Errors that exceed a certain threshold
  - ✓ Excessive Timely Filing issues
  - ✓ Dx and Coding patterns that may indicate cloning of services and records
  - ✓ Upcoding (billing 98942 on the majority of your claims)

DENIALS ON THE RISE

It's very likely that at some point, you will have to fight an "unrighteous" denial.

Some payer's denial rates are in excess of 50%, yet only 11% of these denials are ever appealed

82% of claims that are initially denied and appealed will be overturned.

The cost of appealing a denial may be more than the reimbursement on the claim.

https://www.pbs.org/newshour/health/analysis-health-insurance-claim-denials-are-on-the-rise-to-the-detriment-of-patients

I have a CASH Practice. I DON'T DEAL WITH THE FEDERAL GOVERNMENT

The Feds established the Framework for Corporate Compliance and Ethics

Most States and Regulatory Boards have Adopted these rules:

*"Compliance regulations do overlap as more laws that **protect the public interest** are established. For instance, data protection and identity verification are continuously moving to the forefront of conversations….. In this case, the FTC uses law enforcement and policy initiatives to protect consumers [in the private sector]"*

https://www.thebidlab.com/learning-center/public-vs-private-compliance/#Private_Sector_Transparency

MALPRACTICE SUITS ON THE RISE

Medical documentation issues play a role in 10–20% of medical malpractice lawsuits. Inaccurate, incomplete, or generic records undermine a physician's defense and make a plaintiff's lawyer more likely to take on a case.

Previous studies of malpractice claims involving documentation indicate that these cases most commonly revolve around missing documentation (70%), inaccurate content (22%), or poor mechanics (18%).[3] Poor mechanics includes errors in transcribed order, illegible entries, and delays in documentation.[3] Physicians often focus on documentation as a means of communicating with other physicians and billing for their services, but it is also crucial to communicate with the patient and **provide a legal record of the care provided**

SOURCE: NATIONAL LIBRARY OF MEDICINE https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9183775/

LOOKING TO THE FUTURE

- Rapid expansion in technology and AI is making the possibility of ALL claims being subject to a pre-payment audit a reality in the near future (next 5-10 years).
- Providers will have the ability to send their documentation as a claim attachment so the document can be scanned for claim accuracy before payment is issued
- The push toward ratifying the Chiropractic Medicare Modernization Act, expanding covered services performed and/or ordered by a DC is nearing its fulfillment. This will most likely result in Medicare increasing audits to make sure that DC's know how to properly document for these expanded services.

LOOKING TO THE FUTURE

Administrative Simplification: Adoption of Standards for Health Care Attachments Transactions and Electronic Signatures, and Modification to Referral Certification and Authorization Transaction Standard

(Article Published Dec. 19, 2022)

Summary (Overview)

The Adoption of Standards for Health Care Attachments Transactions and Electronic Signatures, and Modification to Referral Certification and Authorization Transaction Standard (CMS-0053-P), if finalized, would adopt standards for "health care attachments" transactions, which would support health care claims and prior authorization transactions; adopt standards for electronic signatures to be used in conjunction with health care attachments transactions; and adopt a modification to the standard for the referral certification and authorization transaction.

SOURCE: https://www.cms.gov/newsroom/fact-sheets/administrative-simplification-adoption-standards-health-care-attachments-transactions-and-electronic

LOOKING TO THE FUTURE

The proposed health care attachments standards cover **three general use cases**, illustrated below, whereby a provider would submit electronic documentation to a health plan:

Prior Authorization: In this case, a provider must obtain a health plan's approval for a service before it is rendered to the patient. The provider will send a request for approval along with supporting information to the health plan. The plan will then review the information, decide whether this service would be covered, and return a response to the provider indicating the coverage decision. **Although there is currently an adopted HIPAA transaction for the prior authorization request and response, there is no way for a provider to submit documentation to support a prior authorization electronically using HIPAA standards.**

SOURCE: https://www.cms.gov/newsroom/fact-sheets/administrative-simplification-adoption-standards-health-care-attachments-transactions-and-electronic

LOOKING TO THE FUTURE

The proposed health care attachments standards cover three general use cases, illustrated below, whereby a provider would submit electronic documentation to a health plan:

Solicited Documents: In this use case, a provider has submitted a claim for a rendered service and the health plan decides that more information is required to make a payment determination. The health plan requests more information from the provider and the provider responds.

Unsolicited Documents: In this use case, a health care provider submits a claims attachment along with their initial submission of a health care claim transaction for a service they have rendered. This usually occurs when a provider is in a full claims review program with the health plan or the health plan's payment policies require documents with each claim submission for service.

SOURCE: https://www.cms.gov/newsroom/fact-sheets/administrative-simplification-adoption-standards-health-care-attachments-transactions-and-electronic

LOOKING TO THE FUTURE

Health Care Savings

Based on industry research performed by the Council for Affordable Quality Healthcare (CAQH), significant savings could result from the adoption of automated electronic processing of attachments. The 2019 CAQH report indicates that a fully electronic system for prior authorization with health care attachments could result in as much as $454 million in annual savings to the health care industry.[1] Similar savings can be expected for the industry with a switch to health care attachments for claims. **The 2019 CAQH report further estimates the industry could expect as much as $374 million in savings per year with the full adoption of health care attachments for claims. This results in a total expected industry savings, for prior authorization and claims, of $828 million per year.**

SOURCE: https://www.cms.gov/newsroom/fact-sheets/administrative-simplification-adoption-standards-health-care-attachments-transactions-and-electronic

HOW TO IMPLEMENT A SELF AUDIT PROGRAM IN YOUR PRACTICE

FIRST STEPS

- ✓ Hire/train Audit Team
  - ✓ Who will conduct the Audit?
  - ✓ Recommend an experienced and **impartial** Auditor
- ✓ Set a schedule for Audits
  - ✓ **Baseline Audit (what we will focus on today)**
  - ✓ After Baseline, Annually per provider (unless targeted review of non-compliant areas is needed)
  - ✓ Conduct Baseline Audit of new providers' documentation/claims within the first 90 days of employment
  - ✓ Increase annual Audit schedule for non-compliant providers – ie: Monthly x3, then Quarterly
- ✓ Set parameters
  - ✓ How many charts? See Federal Register / Vol. 65, No. 194 / Thursday, October 5, 2000 / Notices
  - ✓ Case types/revenue profiles See Federal Register / Vol. 65, No. 194 / Thursday, October 5, 2000 / Notices

BASELINE AUDIT

The OIG recommends that a baseline, or ''snapshot,'' be used to enable a practice to judge over time its progress in reducing or eliminating potential areas of vulnerability. This practice, known as ''benchmarking,'' allows a practice to chart its compliance efforts by showing a reduction or increase in the number of claims paid and denied.

A baseline audit examines the claim development and submission process, from patient intake through claim submission and payment, and identifies elements within this process that may contribute to non-compliance or that may need to be the focus for improving execution.

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BASELINE AUDIT

The practice's self-audits can be used to determine whether:

• Bills are accurately coded and accurately reflect the services provided (as documented in the medical records);

• Documentation is being completed correctly;

• Services or items provided are reasonable and necessary; and

• Any incentives for unnecessary services exist *(ie: Waiving cost shares, company/supplier kickbacks, etc)*

Federal Register / Vol. 65, No. 194 / Thursday, October 5, 2000 / Notices

BASELINE AUDIT

There are many ways to conduct a baseline audit. The OIG recommends that claims/services that were submitted and paid during the **initial three months after implementation** of the education and training program be examined, so as to give the physician practice a benchmark against which to measure future compliance effectiveness.

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BASELINE AUDIT

Optimally, a randomly selected number of medical records could be reviewed to ensure that the coding was performed accurately.

Although there is no set formula to how many medical records should be reviewed, a **basic guide is five or more medical records per Federal payor (i.e., Medicare, Medicaid), or five to ten medical records per physician.** The OIG realizes that physician practices receive reimbursement from a number of different payors, and we would encourage a physician practice's auditing/monitoring process to consist of a **review of claims from all Federal payors from which the practice receives reimbursement** *(ie: Medicare Advantage Payers)*

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BASELINE AUDIT

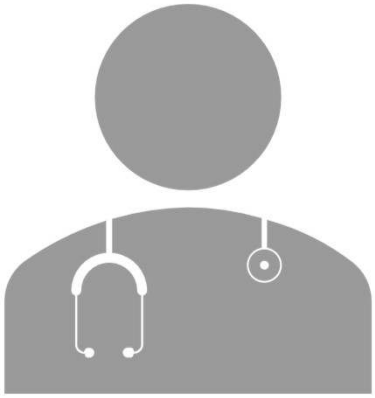
Following the baseline audit, a general recommendation is that periodic audits be conducted **at least once each year** to ensure that the compliance program is being followed.

If problems are identified, **the physician practice will need to determine whether a focused review should be conducted on a more frequent basis**. When audit results reveal areas needing additional information or education of employees and physicians, the physician practice will need to analyze whether these areas should be incorporated into the training and educational system.

Federal Register / Vol. 65, No. 194 / Thursday, October 5, 2000 / Notices


The Low Hanging Fruit of Medical Auditors

The first thing a Medical Auditor will do when reviewing your records is grade them against Ten Standard Documentation Rules

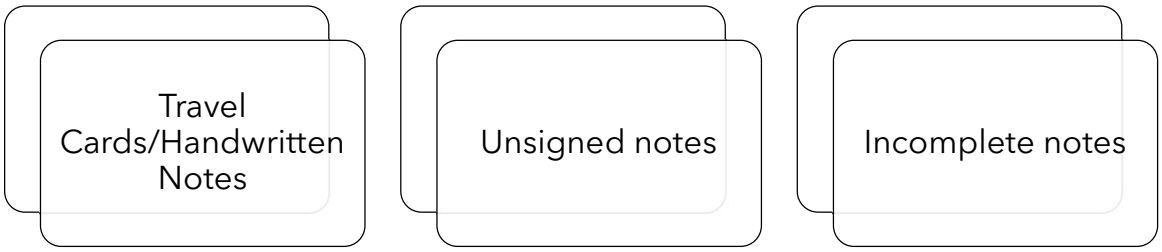


DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

1. The medical record should be complete and legible.

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

RISKY DOCUMENTATION PRACTICE



DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

2. The documentation of each patient encounter should include: the **date**; **reason for the encounter**; **appropriate history and physical exam**; **review of** lab, **X-ray data and other ancillary services and**, when appropriate, **assessment; and a plan of care** (including discharge plan, if appropriate)

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

RISKY DOCUMENTATION PRACTICE

- Missing Chief Complaint
- Failure to refer back to exam/xray findings in relation to the treatment given that day
- Failure to establish and write a Plan of Care (verbal ROF's don't cut it)
- Failure to use the POC to assess and document the patient's response to ongoing treatment

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

3. **Past and present** diagnoses should be accessible to the treating and/or consulting physician

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

RISKY DOCUMENTATION PRACTICE

- Failure to carry the patient's problem list forward to the next date of service
- Failure to adjust diagnoses in the medical record (and claims) as patients respond to care
  - Example, primary dx day 1 of treatment is M54.50 (Low back pain). Patient's pain scale is 8 of 10
  - Day 5, patient's pain scale is 2 of 10 (and has been for the last 3 visits), but M54.50 is still listed as the primary dx for that day's treatment
- Placing dx codes on a claim that do not represent the patient's condition on that day's treatment.

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

4. **The reasons for** and **results of X-rays**, lab tests and **other ancillary services** should be documented or included in the medical record. In many records, **the order and/or intent for the service to be performed is missing.**

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

RISKY DOCUMENTATION PRACTICE

- Missing Radiology report if x-ray was used to diagnose the patient
- X-rays being taken on all patients with no documented justification. "Rule Out" reasons are not valid
- Therapy/Rehab services that are not properly documented (time/frequency/supervision)
- Therapy/Rehab services that were not included in the patient's original POC or updated with a new POC
- Other ancillary services not documented (ie: Acupuncture treatment notes, dispensing of Nutritional supplements)

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

5. Relevant health risk factors should be identified

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

RISKY DOCUMENTATION PRACTICE

- Failure to document and/or refer to patient's lifestyle issues that could contribute to their health problems (ie: Job that requires heavy lifting/repetitive motion, sports activities that may contribute to injury)
- Failure to document co-morbidities (ie: Obesity, High Blood Pressure, Previous Stroke, Osteoporosis, etc)
- Failure to document counseling on co-morbidities (ie: recommendation that patient go on a weight loss program, lose xxx pounds, etc)
- Failure to identify and counsel patients about social determinants preventing good health (smoking, recreational drug use)
- Other ancillary services not documented (ie: Acupuncture treatment notes, dispensing of Nutritional supplements)
- No Outcome Assessment tools (OATS) such as Ostwestry, Midas, VAS, WOMAC, KOOS, etc

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

6. The patient's progress, including response to treatment, change in treatment, change in diagnosis and patient non-compliance should be documented.

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

RISKY DOCUMENTATION PRACTICE

- Failure to use the POC to document whether the patient is responding to treatment as expected, better or worse than expected
- Failure to remove dx codes that no longer apply to the patient's current condition
- Failure to document a change in the patient's POC
- Failure to document missed appointments/cancellations

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

7. The written plan of care should include, when appropriate: treatments and medications, specifying frequency and dosage; any referrals; patient/family education; and specific instructions for follow-up.

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

RISKY DOCUMENTATION PRACTICE

- Failure to write a Plan of Care
- Failure to use the POC as a guideline for future visits
- Writing an incomplete POC (not indicating what interventions will be used throughout the course of treatment, no short or long-term treatment goals)
- If patient's condition may warrant referral for MRI, Surgical intervention, this should be documented as to when you will be assessing the effectiveness of conservative treatments)
- Failure to indicate recommendations for home/self care instructions in the POC

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

8. The documentation should support the medical necessity of the patient evaluation and/or treatment, including thought processes and the complexity of medical decision-making.

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

RISKY DOCUMENTATION PRACTICE

- Failure to establish a reason for care (chief complaint/co-morbidities, etc)
- MDM is fairly complex, but not documented as such. Claim supports complex MDM, but documentation does not.
- Same POC for EVERY PATIENT (common when working with a Practice Management Consultant).
- Failure to review the Payer's Medical Policy guidelines for **their** documentation and coding standards

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

9. All entries to the medical record should be dated and authenticated by physician/provider signature. Medical documentation with missing or invalid signatures fails to meet the CMS signature requirements and may result in claim denial.

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

mln FACT SHEET

Print-Friendly Version

KNOWLEDGE • RESOURCES • TRAINING

Complying with Medicare Signature Requirements

Medicare Signature Requirements

Documentation must meet Medicare's signature requirements. Medicare claims reviewers look for signed and dated medical documentation meeting Medicare signature requirements. If entries aren't signed and dated, they may deny the associated claims.

FAQs

How do we define a handwritten signature?

A mark or sign the ordering or prescribing physician or Non-Physician Practitioner (NPP) makes on a document signifies knowledge, approval, acceptance, or obligation.

What if I use a scribe when documenting medical record entries?

Even if a scribe dictates the entry on your behalf, you must sign the entry to effectively authenticate the documents and care you provided or ordered. It's unnecessary to document who transcribed the entry.

What is required for a valid signature?

A valid signature must be:

- For services you provided or ordered
- Handwritten or electronic
  - We allow stamped signatures if you have a physical disability and can prove to a CMS contractor you're unable to sign due to that disability
- Legible or can be confirmed by comparing to a signature log or attestation statement

Can I avoid delays in claim reviews by sending a signature log or signature attestation with my documentation?

We encourage you to send a complete medical record with proper signature documentation first to avoid medical review delays. This includes a signature log or attestation if needed.

Must I date my signatures?

Documentation must have enough information to show the date you ordered or performed the services. If you dated the entries immediately above and below an undated entry, medical review may reasonably assume the entry date in question.

What are the medical review guidelines for using an electronic signature?

The medical review guidelines for using an electronic signature are:

- Systems and software products must include protections against modification, and you should apply administrative safeguards that meet all standards and laws.
- The individual's name on the alternate signature method and the provider accept responsibility for the authenticity of attested information.

RISKY DOCUMENTATION PRACTICE

- Unsigned notes
- Illegible Signature with no accompanying signature log
- Missing provider credentials (ie: DC, DPT, APRN, etc)
- One provider rendering services for another and signing the note as if it is the other provider (locum tenens providers should sign their own note, "acting as a covering/locum provider for Dr _____")
- Notes not signed in a timely manner

WHAT IS CONSIDERED A TIMELY NOTE?

Medicare providers must comply with documentation requirements, including the timeliness of documentation in connection with the provider signature. Unless the documentation for a service is completed; including signature; a provider cannot submit the service to Medicare. **Medicare states if the service was not documented, then it was not done.**

Providers are expected to complete the documentation of services "during or as soon as practicable after it is provided in order to maintain an accurate medical record." This statement is from the Centers for Medicare & Medicare Services (CMS) Internet-Only Manual (IOM) Publication 100-04, Chapter 12, (PDF) Section 30.6.1. **CMS does not provide any specific period, but a reasonable expectation would be no more than a couple of days away from the service itself.**

SOURCE:
https://www.palmettogba.com/palmetto/jma.nsf/DIDC/9VTLBC1017~Comprehensive%20Error%20Rate%20Testing%20(CERT)~Documentation#:~:text=CMS%20does%20not%20provide%20any,away%20from%20the%20service%20itself.

DOCUMENTATION STANDARDS FOR ALL TYPES OF HEALTCARE DISCIPLINES

10. The CPT/HCPCS/ICD-10-CM codes reported on the claim should reflect the documentation in the medical record.

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027438

RISKY DOCUMENTATION PRACTICES

- CPT/HCPCS Codes on the claim do not match the information in the medical record
- Dx/ICD10 codes on the claim that are irrelevant to the treatment given that day and documented in the medical record
- Procedures that are billed on a claim not represented in the note or Plan of Care
- SALTING NOTES

YOUR CLAIM SHOULD BE AN EXACT MIRROR OF YOUR DOCUMENTATION

WHAT YOU NEED FOR AN ACCURATE AUDIT

- ✓ **A MEDICAL POLICY/GUIDELINE:** The payers publish medical policies that define medical necessity and the documentation requirements needed to establish MN.
- ✓ **A BILLING POLICY/GUIDELINE**: Payers publish reimbursement/coding policies that define specific codes and/or modifiers that would be acceptable on a claim. Remember that these codes must support both the Medical Policy/Guideline and the information contained in your SOAP/Chart Note.
- ✓ **AN AUDIT WORKSHEET/TEMPLATE:** Use a template to make sure you are addressing all areas of documentation compliance

MEDICARE POLICY

NCD/NATIONAL COVERAGE DETERMINATION

Policies that are to be followed throughout the USA. Not specific to a certain payer/MAC

MEDICARE BENEFIT POLICY MANUAL

Chapter 15: Covered Medical and Other Health Services (National Policy)

LCD/LOCAL COVERAGE DETERMINATION

Published by the MAC

Provides information on how to establish medical necessity, limitations and documentation requirements for initial and subsequent visits

LCA/LOCAL COVERAGE ARTICLE

Published by the MAC

Provides Billing and Coding Guidance

Medicare coverage of chiropractic

30.5 - Chiropractor's Services
(Rev. 23, Issued: 10-08-04, Effective: 10-01-04, Implementation: 10-04-04)
B3-2020.26

A chiropractor must be licensed or legally authorized to furnish chiropractic services by the State or jurisdiction in which the services are furnished. In addition, a licensed chiropractor must meet the following uniform minimum standards to be considered a physician for Medicare coverage. Coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation provided such treatment is legal in the State where performed. All other services furnished or ordered by chiropractors are not covered.

240.1.2 - Subluxation May Be Demonstrated by X-Ray or Physician's Exam

2. Demonstrated by Physical Examination

Evaluation of musculoskeletal/nervous system to identify:

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

Asymmetry/misalignment identified on a sectional or segmental level;

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

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

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

Establish medical necessity

PART EXAM

240.1.2 - Subluxation May Be Demonstrated by X-Ray or Physician's Exam

An x-ray may be used to document subluxation. The x-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific x-ray evidence is warranted, an x-ray is considered reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted provided the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent. A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.

Establish medical necessity

CONDITIONS THAT WARRANT ACTIVE TREATMENT (AT MODIFIER)

- Acute subluxation-A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.

CONDITIONS THAT WARRANT ACTIVE TREATMENT (AT MODIFIER)

- Chronic subluxation-A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

HOW MANY VISITS?....

240.1.5 - Treatment Parameters
(Rev. 23, Issued: 10-08-04, Effective: 10-01-04, Implementation: 10-04-04)
B3-2251.5

The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxation (e.g., strains or sprains) problems may require as many as three months of treatment but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.

Chronic spinal joint condition implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already "set" and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

MAINTENANCE THERAPY

B. Maintenance Therapy

Under the Medicare program, Chiropractic maintenance therapy is not considered to be medically reasonable or necessary, and is therefore not payable. Maintenance therapy is 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. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. For information on how to indicate on a claim a treatment is or is not maintenance, see §240.1.3.

Article - Billing and Coding: Chiropractic Services (A58345)

When billing for Chiropractic services:

- Report the initial treatment or date of exacerbation. CMS1500 BOX 14
- Specify the precise spinal location and level of subluxation. PATIENT'S CHART
- Report the date of X-ray if an X-ray is used to demonstrate subluxation. CMS1500 BOX 19
- Report the level of subluxation using the appropriate ICD-10-CM code. CMS1500 BOX 21, 24E (A) = M99.XX
- In addition to reporting the ICD-10-CM code for the level of subluxation, report any other pertinent ICD-10-CM codes. CMS1500 BOX 21, 24E (B) = SECONDARY DX
- All treatments must be categorized as acute subluxation, chronic subluxation or maintenance therapy. An exacerbation of a previous injury should be categorized into either "acute" or "chronic" (e.g., an identifiable re-injury would fall under acute). PATIENT'S CHART

GOLD STAR MEDICAL BUSINESS SERVICES HTTPS://GOLDSTARMEDICAL.NET INFO@GOLDSTARMEDICAL.NET 866-942-5655

Article - Billing and Coding: Chiropractic Services (A58345)

The following modifiers should be reported with CPT codes 98940, 98941, and 98942 as is appropriate to each patient's situation:

- AT – Acute treatment
- GA – Waiver of liability statement issued as required by payer policy, individual case. Authorization has been provided to notify the beneficiary of the likelihood that services rendered will be denied as not reasonable and medically necessary under Medicare guidelines.
- GZ – Item or service expected to be denied as not reasonable and necessary

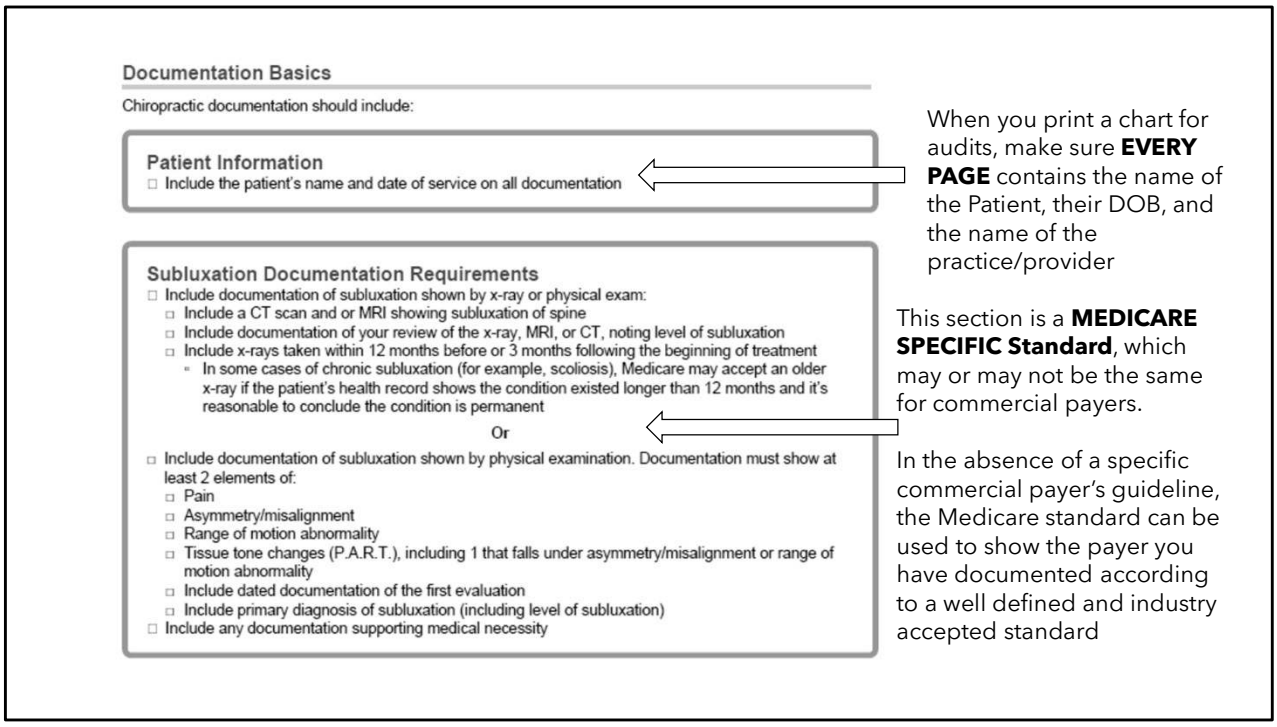
Chiropractic Specific Documentation (Medicare Standard)

The "Medicare Standard" for Chiropractic and Physical Therapy provides a very solid framework for good documentation.

The Medicare Standard must always be compared against specific payer standards.

Medicare has provided DC's with an audit template, called the Chiropractic Job Aid

Medicare Documentation Job Aid for Chiropractic Doctors



When you print a chart for audits, make sure **EVERY PAGE** contains the name of the Patient, their DOB, and the name of the practice/provider

This section is a **MEDICARE SPECIFIC Standard**, which may or may not be the same for commercial payers.

In the absence of a specific commercial payer's guideline, the Medicare standard can be used to show the payer you have documented according to a well defined and industry accepted standard

DOCUMENTATION ELEMENTS THAT JUSTIFY YOUR E/M CODE

Initial Evaluation

- ☐ History
  - ☐ Date of initial treatment.
  - ☐ Description of current illness.
  - ☐ Symptoms related to level of subluxation causing patient to seek treatment.
  - ☐ Family history (recommended).
  - ☐ Past health history (recommended).
  - ☐ Mechanism of trauma (recommended).
  - ☐ Quality and character of symptoms or problem (recommended).
  - ☐ Onset, duration, intensity, frequency, location, and radiation of symptoms (recommended).
  - ☐ Aggravating or relieving issues (recommended).
  - ☐ Past interventions, treatments, medication, and secondary complaints (recommended).
- ☐ Contraindications (for example, risk of injury to patient from dynamic thrust or discussion of risk with patient) (recommended).
- ☐ Physical examination (P.A.R.T.).
  - ☐ Evaluation of musculoskeletal and nervous system through physical examination.
- ☐ Treatment given on day of visit (if relevant).
  - ☐ Include specific areas and levels of the spine that you manipulated.
  - ☐ Medicare may cover treatment using hand-held devices. But Medicare doesn't offer more payment or recognize an extra charge for use of the device.

Treatment Plan

- ☐ Frequency and duration of visits (recommended)
- ☐ Specific treatment goals (recommended)
- ☐ Objective measures to evaluate treatment effectiveness (recommended) ⇦ **OATS!**

Subsequent Visits

- ☐ History
  - ☐ Review of chief complaint
  - ☐ Changes since last visit
  - ☐ System review, if relevant
- ☐ Physical examination (P.A.R.T.)
  - ☐ Assessment of change in patient's condition since last visit
  - ☐ Evaluation of treatment effectiveness
- ☐ Treatment given on day of visit (include specific areas and levels of spine that you manipulated)

General Guidelines

- Make sure medical records show that the service is a corrective treatment, not a maintenance treatment.
  - For Medicare purposes, place an AT modifier on a claim when you give active or corrective treatment for acute or chronic subluxation.
    - Don't use an AT modifier for maintenance therapy.
    - Only use an AT modifier when chiropractic manipulation is reasonable and necessary as defined by national and local policy.
    - **Note:** An AT modifier doesn't prove the service is reasonable and necessary. As always, contractors can deny a claim after medical review.

    Make sure you know these policies, along with any local coverage determination in your area, to better understand how active or corrective chiropractic services are covered.

- Include records for all dates of service on a claim.
- Make sure documentation is legible and complete, including signatures.
- Include legible signatures and credentials of professionals providing services.
  - If signatures are missing or illegible, include a completed signature attestation statement.
  - For illegible signatures, include a signature log.
  - For electronic health records, include a copy of electronic signature policy and procedures describing how notes and orders are signed and dated. Validating electronic signatures depends on getting this information.
- Include abbreviation key (if relevant).
- Include any other documentation to support medical necessity of services billed, as well as documentation specifically asked for in an additional documentation request (ADR) letter.
- Include a copy of the Advance Beneficiary Notice of Noncoverage (if relevant).

General Documentation Guidelines for All Disciplines

OTHER CHIROPRACTIC DOCUMENTATION RISKS

TOO MUCH S.A.L.T. IS BAD FOR YOU

S.A.L.T. = Same as last time

Most Chiropractic EMR systems have the ability for you to SALT your note from one visit to the next

Allows for quicker notes, but has inherent risks

TOO MUCH S.A.L.T. IS BAD FOR YOU

- **Risks of SALTed notes**
  - Not making necessary written modifications to the note for that day's treatment
  - Not removing codes that are irrelevant/not applicable to that day's treatment
  - Not responding to changes in patient's condition in the note
  - Failure to modify and update the POC when needed

ELEMENTS OF A COMPLETE MEDICAL RECORD (PATIENT/ADMIN FORMS)

*Most payers will require that you send these forms/documents if/when you are subject to a post payment audit.

- *Patient Intake Forms
- *OATS – to be filled out by the patient at initial exam, re-exams, or new diagnosis (ie: Oswestry, Midas, etc)
- Copies of Patient's insurance cards (front and back)
- *NSA Forms (Notice of Non-Participation in patient's plan, Good Faith Estimate)
- Insurance Questionnaire/Verification of Benefits
- *ABN's
- *Copies of PA's/Referrals, if applicable
- *Accident Questionnaire/Copies of Police or Employer Reports (for PI or WC cases)

ELEMENTS OF A COMPLETE MEDICAL RECORD (PROVIDER FORMS)

- Initial/Subsequent Exam notes
- Daily Procedure notes
- Exam forms (PART, Record of Ortho/Neuro Tests performed)
- Written Plan Of Care
- Copies of Prior Medical Records, if relevant
- Imaging reports/studies
- Therapy/rehab flow sheets, if applicable

FORMS FROM YOUR EMR

Check with your EMR software vendor to find out what patient forms and/or templates are available for your, or your patient's use. Many software programs designed for chiropractic have templates of relevant forms, including OATS, consult forms, intake forms, etc. Save time by having patient fill out online forms that save directly to their chart.

FORMS EXAMPLES

Copies of these forms are available on request. May be used to create your own fillable documents or templates. Request copies of forms by emailing Lisa Maciejewski-West at info@goldstarmedical.net

Refer to the Forms Disclaimer for more information.

NAME OF CLINIC

NEW PATIENT INTAKE FORM

Date:_____ Patient #_____ **Doctor/Provider:_____**

Name:_____ Primary Phone: _____ (circle) Home Cell Work
Address:_____City:_____ State:_____ Zip:_____
E-mail address:_____ Alternate Phone: _____
MAY WE: (circle all that apply) CALL CELL CALL HOME CALL WORK EMAIL MAIL **you about**
APPOINTMENT REMINDERS ACCOUNT UPDATES CLINIC EVENTS BIRTHDAYS/ANNIVERSARIES
Age:_____ Birth Date:_____ Race:_____ Marital: M S W D
Occupation:_____ Employer:_____
Employer's Address:_____ Office Phone:_____
Spouse:_____ Occupation:_____ Employer:_____
How many children?_____Names and Ages of Children:_____
_____
Name of Nearest Relative:_____ Address:_____Phone:_____
How were you referred to our office?_____

Please check any and all insurance coverage that may be applicable in this case:

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident
☐ Medical Savings Account & Flex Plans ☐ Other/Non-Insured/Cash

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the provider or clinic. I authorize my provider to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of medical care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____
_____

Patient's Signature:_____ Date:_____
Guardian's Signature Authorizing Care:_____ Date:_____

REVIEWED BY:
DATE:
PRINT NAME:

NAME OF CLINIC/PROVIDER_____
PATIENT NAME _____ PATIENT DOB _____
DATE _____ Doctor_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____
WHEN DID SYMPTOMS APPEAR? _____ Are they getting worse? ☐ YES ☐ NO
IF VISIT IS DUE TO ACCIDENT Date accident happened (if applicable): _____
Is this due to: Auto___ Work___ Other_____
Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe:_____
_____
Days lost from work:_____ Date of last physical examination:_____
Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____
_____
Have you been treated for any health condition by a physician in the last year? ☐Yes ☐ No
If yes, describe:_____
What medications or drugs are you taking?_____
_____
Do you have any allergies to any medications? ☐ Yes ☐ No
If yes, describe:_____
Do you have any allergies of any kind? ☐ Yes ☐ No
If yes, describe:_____
Do you have any Congenital Condition? ☐Yes ☐ No If YES, Describe _____
_____
Women: Are you pregnant?_____ Date of last Menstrual Period _____

HEALTH ISSUES AND CONDITIONS: Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now P = Previously

Headaches_____ Frequency	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____

REVIEWED BY:
DATE:
PRINT NAME:

NAME OF CLINIC/PROVIDER_____

PATIENT NAME _____ DOB _____

DATE _____ Doctor_____

HEALTH ISSUES AND CONDITIONS (Continued)

Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alchoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Depression	_____
Ulcers	_____		

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use - Daily Occasionally Never

_____ Drug Use - Daily Occasionally Never

_____ Tobacco Use - Daily Occasionally Never

_____ Caffeine - Daily Occasionally Never

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

REVIEWED BY:
DATE:
PRINT NAME:

NAME OF CLINIC/PROVIDER_____

PATIENT NAME _____ DOB _____

DATE _____ Doctor_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

REVIEWED BY:
DATE:
PRINT NAME:

CONSULTATION QUESTIONNAIRE-HISTORY OF PRESENT ILLNESS

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying?_____
3. If this is a recurrence, when was the first time you noticed this problem?_____
   How did it originally occur?_____
   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ____
   If yes, when and how? _____
4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___
   How long does it last? All Day _____ Few Hours _____ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____. If yes, describe: _____
   Are there other unrelated health problems? Yes _____ No _____ If yes, describe _____
   _____
6. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching ____
   Burning _____ Stabbing _____ Other _____
7. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____
   _____. If no, what have you tried to do that has not helped? _____
   _____
8. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending ____
   Lifting _____ Twisting _____ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____
   _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____
11. Remarks: _____
    _____
    _____

NO SYMPTOMS ——— EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

Patient/Guardian Signature_____ Date _____

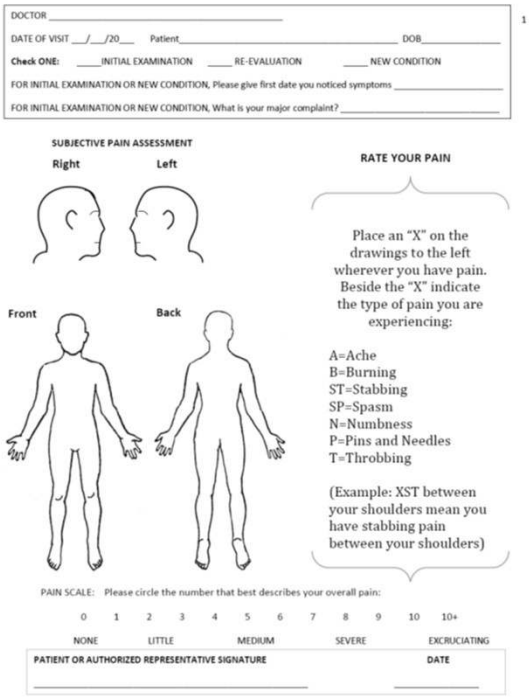
Provider Signature _____ Date _____

1

CONSULTATION QUESTIONNAIRE

ACCORDING TO E/M CODING GUIDELINES, THIS PART OF THE PATIENT'S HISTORY CAN BE RECORDED BY ANCILLARY STAFF AND REVIEWED/CONFIRMED BY PROVIDER DURING THE EXAM.

SAVE PROVIDER TIME. TRAIN YOUR BACK OFFICE CA/MA ON HOW TO DO THE INITIAL CONSULT.



DOCTOR _____

DATE OF VISIT __/__/20__ Patient_____ DOB_____

Check ONE: _____INITIAL EXAMINATION _____RE-EVALUATION _____NEW CONDITION

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms _____

FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? _____

1

SUBJECTIVE PAIN ASSESSMENT

Right **Left**

Front **Back**

RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

_____ _____

Example of Medicare PART Exam Form

Page 1 of this form can be used as a daily Subjective Assessment that is filled out by the patient before each treatment.

By modifying the text slightly (at the top of the form) you can use this for the patient to indicate chief pain complaint for that day.

DOCTOR_____

DATE OF VISIT ___/___/20___ Patient_____ DOB_____

Check ONE: _____INITIAL EXAMINATION _____RE-EVALUATION _____NEW CONDITION

2

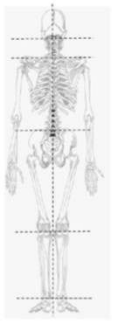
C0
C1
C2
C3
C4
C5
C6
C7
L1
L2
L3
L4
L5
SAC
L-IL
R-IL

ASYMMETRY

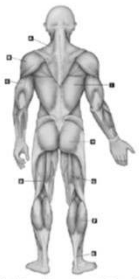
USING ARROWS

Mark the Misaligned Vertebrae

T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12



TISSUE ABNORMALITIES



A _____
B _____
C _____
D _____
E _____
F _____
G _____
H _____
I _____

Mark Tissue Abnormalities: TP=Trigger Points, LG=Ligaments (Swollen/Tender), TN=Tendons, SK=Skin, FS=Fascial Restrictions, SP=Spasm, TI=Tightness

RANGE OF MOTION ASSESSMENT

CERVICAL	NORMAL	PAIN	LUMBAR	NORMAL	PAIN
Flexion	50		Flexion	60	
Extension	60		Extension	25	
Left Lat Flex	45		Left Lat Flex	25	
Right Lat Flex	45		Right Lat Flex	25	
Left Rotation	80		Left Rotation	30	
Right Rotation	80		Right Rotation	30	

DOCTOR SIGNATURE **DATE**

DOCTOR_____

DATE OF VISIT ___/___/20___ Patient_____ DOB_____

Check ONE: _____INITIAL EXAMINATION _____RE-EVALUATION _____NEW CONDITION

3

EXAMINATION

B/P: _____ PULSE: _____ RESP: _____ HT: _____ WT: _____ GRIP: (L)_____ (R)_____

REFLEXES (Wexler Scale)

Biceps _____
Triceps _____
Brac/rad _____
Patella _____
Achilles _____

SENSORY: C5:_____ C6:_____ C7:_____ C8:_____ T1:_____ L3:_____ L4:_____ L5:_____ S1:_____ **D=Deficit N=Normal (L) or (R)**

GENERAL ORTHO/NEURO EXAMINATION: (+) or (-), (L) or (R)

Spinous Percus: _____ Babinski _____ Brudzinski _____

Dejerine Triad _____ Rhomberg _____ Valsalva _____

TEST	(+)	(-)	L	R	INDICATION
Distraction					Nerve Root Compression
Jackson					Nerve Root Compression
Max Cerv Root Compression					Nerve Root Compression
Cervical Compression					Nerve Root Compression
Soto Hall					(cervl/thor) Vertebral Trauma
Spurling's					Nerve Root Irritation
Shoulder Depression					Nerve Root Compression
Ulsman's					(low) (normal) (high) Pain Threshold
Burn's Bench					(hysteria) (Meinegerina)
Hoover's					(hysterical paralysis) (Meinegerina)
Bechterew					Sciatic Disc Compression
Beevor's					Abdominal Muscle Weakness
Minor's Sign					Radicular Disc Pain
Ely					Upper Lumbar Lesion
Fajerstein					Intervertebral Disc Syndrome
Nachlas					Upper Lumbar Lesion
Gluteal Punch					Spinal Lesion
Goldthwaite					Lumbar Differentiation
Heel-toe Walk					5th Lumbar Motor Deficit
Kemps					Intervertebral Disc Rupture
Lasegue					(Muscle) (Disc) (Nerve) Irritation
Braggards					Lumbar Antalgic Spasm
Supported Adam's					Lumbosacral Differentiation

MUSCLE TESTS

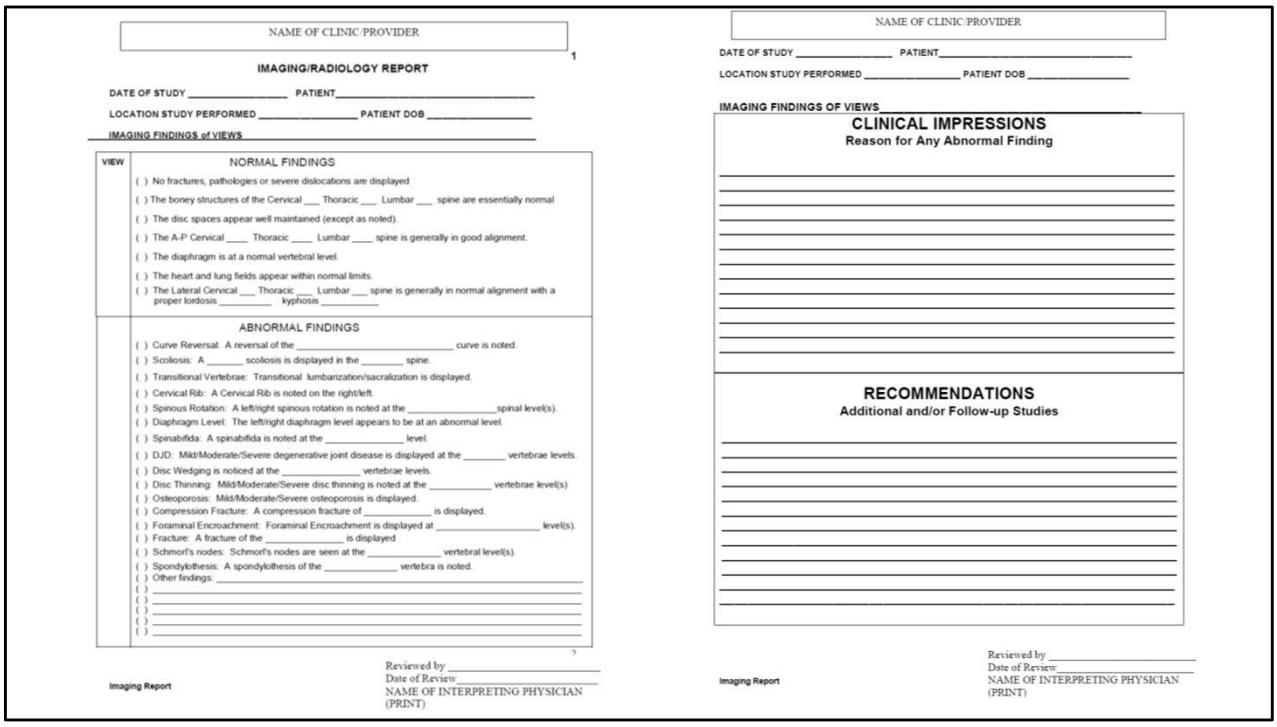
LEVEL	Muscle	Muscle Grade L	Muscle Grade R
C5	Deltoids	L:	R:
C6	Biceps	L:	R:
	Wrist Extensors	L:	R:
C7	Triceps	L:	R:
	Wrist Flexors	L:	R:
	Finger Extensors	L:	R:
C8	Finger Flexors	L:	R:

LEVEL	Muscle	Muscle Grade L	Muscle Grade R
T1	Finger Abductors	L:	R:
L2-L3	Hip Flexors	L:	R:
L4-L5	Hip Extensors	L:	R:
L3-L4	Knee Extensors	L:	R:
L5-S1	KneeFlexors	L:	R:
L4-L5	Ankle Extensors	L:	R:
S1-S2	Ankle Flexors	L:	R:

DIAGNOSIS: _____

_____

DOCTOR SIGNATURE **DATE**



NAME OF CLINIC/PROVIDER

1

IMAGING/RADIOLOGY REPORT

DATE OF STUDY _____ PATIENT_____

LOCATION STUDY PERFORMED _____ PATIENT DOB _____

IMAGING FINDINGS of VIEWS_____

VIEW	NORMAL FINDINGS
	( ) No fractures, pathologies or severe dislocations are displayed.
	( ) The boney structures of the Cervical ___ Thoracic ___ Lumbar ___ spine are essentially normal
	( ) The disc spaces appear well maintained (except as noted).
	( ) The A-P Cervical ____ Thoracic ____ Lumbar ____ spine is generally in good alignment.
	( ) The diaphragm is at a normal vertebral level.
	( ) The heart and lung fields appear within normal limits.
	( ) The Lateral Cervical ___ Thoracic ___ Lumbar ___ spine is generally in normal alignment with a proper lordosis _____ kyphosis _____
	ABNORMAL FINDINGS
	( ) Curve Reversal: A reversal of the _____ curve is noted.
	( ) Scoliosis: A _____ scoliosis is displayed in the _____ spine.
	( ) Transitional Vertebrae: Transitional lumbarization/sacralization is displayed.
	( ) Cervical Rib: A Cervical Rib is noted on the right/left.
	( ) Spinous Rotation: A left/right spinous rotation is noted at the _____spinal level(s).
	( ) Diaphragm Level: The left/right diaphragm level appears to be at an abnormal level.
	( ) Spinabifida: A spinabifida is noted at the _____ level.
	( ) DJD: Mild/Moderate/Severe degenerative joint disease is displayed at the _____ vertebrae levels.
	( ) Disc Wedging is noticed at the _____ vertebrae levels.
	( ) Disc Thinning: Mild/Moderate/Severe disc thinning is noted at the _____ vertebrae level(s)
	( ) Osteoporosis: Mild/Moderate/Severe osteoporosis is displayed.
	( ) Compression Fracture: A compression fracture of _____ is displayed.
	( ) Foraminal Encroachment: Foraminal Encroachment is displayed at _____ level(s).
	( ) Fracture: A fracture of the _____ is displayed.
	( ) Schmorl's nodes: Schmorl's nodes are seen at the _____ vertebral level(s).
	( ) Spondylothesis: A spondylothesis of the _____ vertebra is noted.
	( ) Other findings: _____
	( ) _____
	( ) _____
	( ) _____
	( ) _____
	( ) _____

2

Imaging Report

Reviewed by _____
Date of Review_____
NAME OF INTERPRETING PHYSICIAN
(PRINT)

NAME OF CLINIC/PROVIDER

DATE OF STUDY _____ PATIENT_____

LOCATION STUDY PERFORMED _____ PATIENT DOB _____

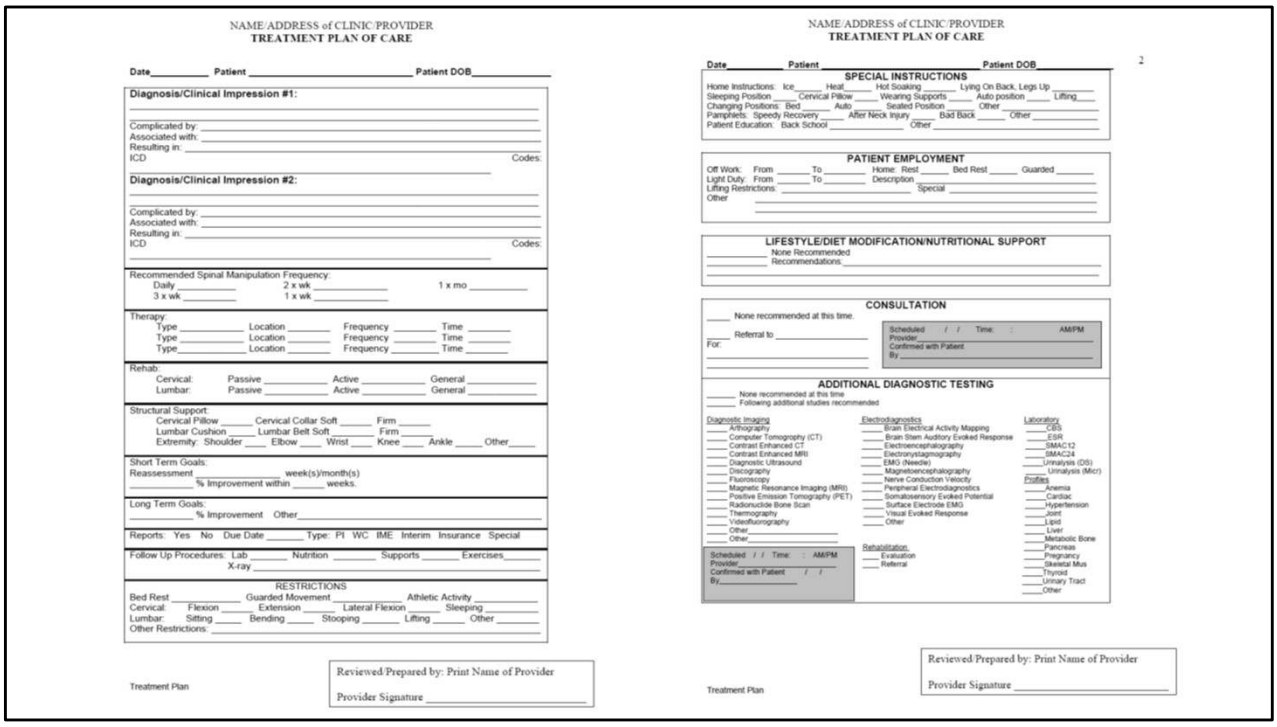
IMAGING FINDINGS OF VIEWS_____

CLINICAL IMPRESSIONS
Reason for Any Abnormal Finding

RECOMMENDATIONS
Additional and/or Follow-up Studies

Imaging Report

Reviewed by _____
Date of Review_____
NAME OF INTERPRETING PHYSICIAN
(PRINT)



NAME/ADDRESS of CLINIC/PROVIDER

TREATMENT PLAN OF CARE

Date_____ **Patient** _____ **Patient DOB**_____

Diagnosis/Clinical Impression #1:

_____

Complicated by: _____

Associated with: _____

Resulting in: _____

ICD _____ Codes:

Diagnosis/Clinical Impression #2:

_____

Complicated by: _____

Associated with: _____

Resulting in: _____

ICD _____ Codes:

Recommended Spinal Manipulation Frequency:

Daily _____ 2 x wk _____ 1 x mo _____

3 x wk _____ 1 x wk _____

Therapy:

Type _____ Location _____ Frequency _____ Time _____

Type _____ Location _____ Frequency _____ Time _____

Type _____ Location _____ Frequency _____ Time _____

Rehab:

Cervical: Passive _____ Active _____ General _____

Lumbar: Passive _____ Active _____ General _____

Structural Support:

Cervical Pillow _____ Cervical Collar Soft _____ Firm _____

Lumbar Cushion _____ Lumbar Belt Soft _____ Firm _____

Extremity: Shoulder ____ Elbow ____ Wrist ____ Knee ____ Ankle _____ Other____

Short Term Goals:

Reassessment _____ week(s)/month(s)

_____ % Improvement within _____ weeks.

Long Term Goals:

_____ % Improvement Other_____

Reports: Yes No Due Date _____ Type: PI WC IME Interim Insurance Special

Follow Up Procedures: Lab _____ Nutrition _____ Supports _____ Exercises_____

X-ray _____

RESTRICTIONS

Bed Rest _____ Guarded Movement _____ Athletic Activity _____

Cervical: Flexion _____ Extension _____ Lateral Flexion _____ Sleeping _____

Lumbar: Sitting _____ Bending _____ Stooping _____ Lifting _____ Other _____

Other Restrictions: _____

Reviewed/Prepared by: Print Name of Provider

Provider Signature _____

Treatment Plan

NAME/ADDRESS of CLINIC/PROVIDER

TREATMENT PLAN OF CARE

2

Date_____ **Patient** _____ **Patient DOB**_____

SPECIAL INSTRUCTIONS

Home Instructions: Ice_____ Heat_____ Hot Soaking _____ Lying On Back, Legs Up _____

Sleeping Position ____Cervical Pillow _____ Wearing Supports _____ Auto position _____ Lifting____

Changing Positions: Bed _____ Auto _____ Seated Position _____ Other_____

Pamphlets: Speedy Recovery ____ After Neck Injury _____ Bad Back _____ Other _____

Patient Education: Back School _____ Other _____

PATIENT EMPLOYMENT

Off Work: From _____ To _____ Home: Rest _____ Bed Rest _____ Guarded _____

Light Duty: From _____ To _____ Description _____

Lifting Restrictions: _____ Special _____

Other _____

LIFESTYLE/DIET MODIFICATION/NUTRITIONAL SUPPORT

_____ None Recommended

_____ Recommendations _____

CONSULTATION

_____ None recommended at this time.

_____ Referral to _____

For:

Scheduled / / Time: : AM/PM

Provider_____

Confirmed with Patient

By: _____

ADDITIONAL DIAGNOSTIC TESTING

_____ None recommended at this time

_____ Following additional studies recommended

Diagnostic Imaging

____ Arthrography
____ Computer Tomography (CT)
____ Contrast Enhanced CT
____ Contrast Enhanced MRI
____ Diagnostic Ultrasound
____ Discography
____ Fluoroscopy
____ Magnetic Resonance Imaging (MRI)
____ Positive Emission Tomography (PET)
____ Radionuclide Bone Scan
____ Thermography
____ Videofluorography
____ Other_____
____ Other_____

Electrodiagnostics

____ Brain Electrical Activity Mapping
____ Brain Stem Auditory Evoked Response
____ Electroencephalography
____ Electronystagmography
____ EMG (Needle)
____ Magnetoencephalography
____ Nerve Conduction Velocity
____ Peripheral Electrodiagnostics
____ Somatosensory Evoked Potential
____ Surface Electrode EMG
____ Visual Evoked Response
____ Other

Laboratory

____CBS
____ESR
____SMAC12
____SMAC24
____Urinalysis (DS)
____ Urinalysis (Micr)

Profiles

____Anemia
____Cardiac
____Hypertension
____Joint
____Lipid
____Liver
____Metabolic Bone
____Pancreas
____Pregnancy
____Skeletal Mus
____Thyroid
____Urinary Tract
____Other

Scheduled / / Time: : AM/PM

Provider_____

Confirmed with Patient / /

By:_____

Rehabilitation:

____ Evaluation
____ Referral

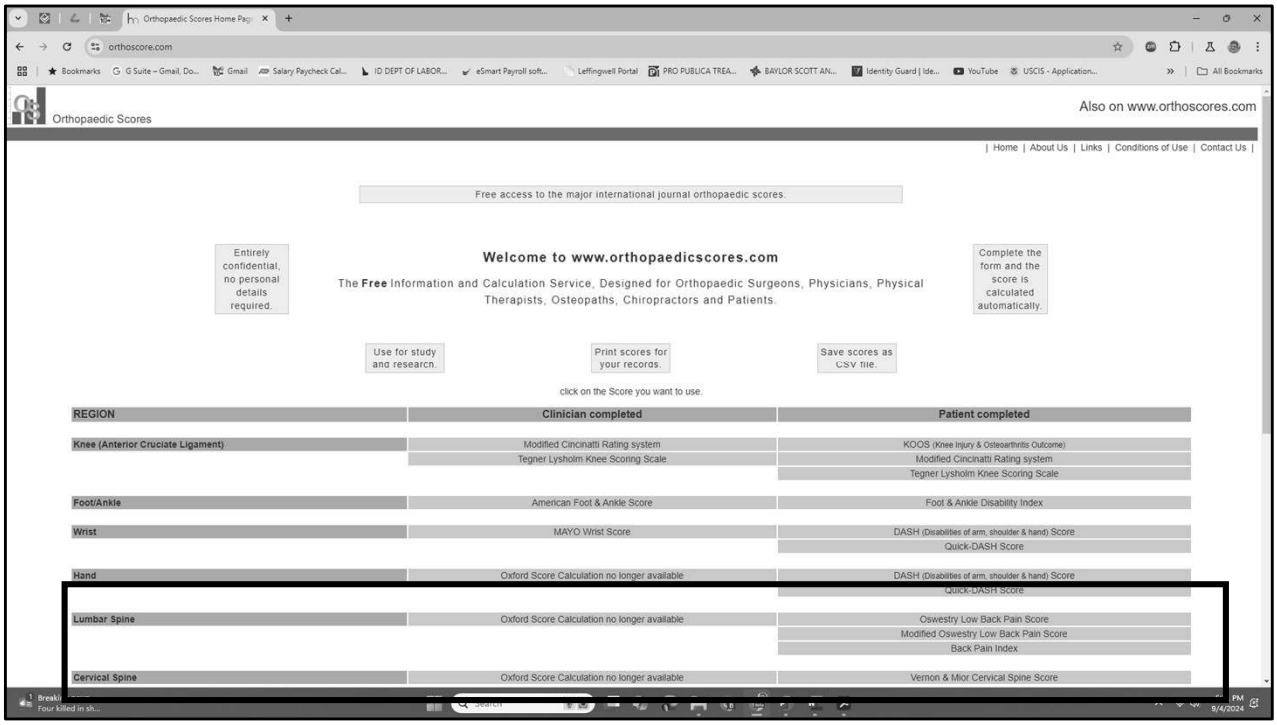
Reviewed/Prepared by: Print Name of Provider

Provider Signature _____

Treatment Plan

OATS

- Check with your EMR to see if OATS are available
- Online Tool: https://orthopaedicscore.com
  - Use this tool to have patient fill out online. Automatically grades the assessment.
  - Create a PDF and upload to patient's chart or print (if still using paper charts)
  - Available for multiple anatomical areas/extremities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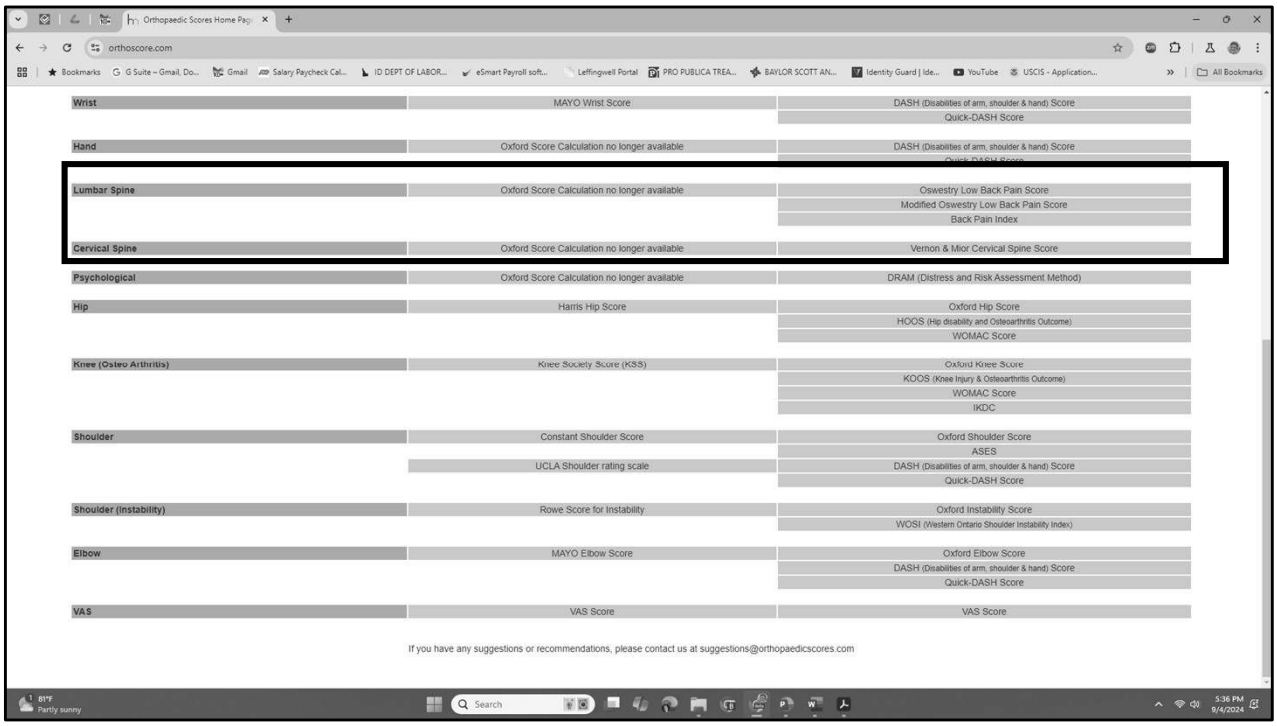
Complete the form and the score is calculated automatically.
Use for study and research.
Print scores for your records.
Save scores as CSV file.
click on the Score you want to use.
REGION
Clinician completed
Patient completed
Knee (Anterior Cruciate Ligament)
Modified Cincinatti Rating system
Tegner Lysholm Knee Scoring Scale
KOOS (Knee Injury & Osteoarthritis Outcome)
Modified Cincinatti Rating system
Tegner Lysholm Knee Scoring Scale
Foot/Ankle
American Foot & Ankle Score
Foot & Ankle Disability Index
Wrist
MAYO Wrist Score
DASH (Disabilities of arm, shoulder & hand) Score
Quick-DASH Score
Hand
Oxford Score Calculation no longer available
DASH (Disabilities of arm, shoulder & hand) Score
Quick-DASH Score
Lumbar Spine
Oxford Score Calculation no longer available
Oswestry Low Back Pain Score
Modified Oswestry Low Back Pain Score
Back Pain Index
Cervical Spine
Oxford Score Calculation no longer available
Vernon & Mior Cervical Spine Score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Identity Guard | Ide...
YouTube
USCIS - Application...
All Bookmarks
Wrist
MAYO Wrist Score
DASH (Disabilities of arm, shoulder & hand) Score
Quick-DASH Score
Hand
Oxford Score Calculation no longer available
DASH (Disabilities of arm, shoulder & hand) Score
Lumbar Spine
Oxford Score Calculation no longer available
Oswestry Low Back Pain Score
Modified Oswestry Low Back Pain Score
Back Pain Index
Cervical Spine
Oxford Score Calculation no longer available
Vernon & Mior Cervical Spine Score
Psychological
Oxford Score Calculation no longer available
DRAM (Distress and Risk Assessment Method)
Hip
Harris Hip Score
Oxford Hip Score
HOOS (Hip disability and Osteoarthritis Outcome)
WOMAC Score
Knee (Osteo Arthritis)
Knee Society Score (KSS)
Oxford Knee Score
KOOS (Knee Injury & Osteoarthritis Outcome)
WOMAC Score
IKDC
Shoulder
Constant Shoulder Score
Oxford Shoulder Score
ASES
UCLA Shoulder rating scale
DASH (Disabilities of arm, shoulder & hand) Score
Quick-DASH Score
Shoulder (instability)
Rowe Score for Instability
Oxford Instability Score
WOSI (Western Ontario Shoulder Instability Index)
Elbow
MAYO Elbow Score
Oxford Elbow Score
DASH (Disabilities of arm, shoulder & hand) Score
Quick-DASH Score
VAS
VAS Score
VAS Score
If you have any suggestions or recommendations, please contact us at suggestions@orthopaedicscores.com
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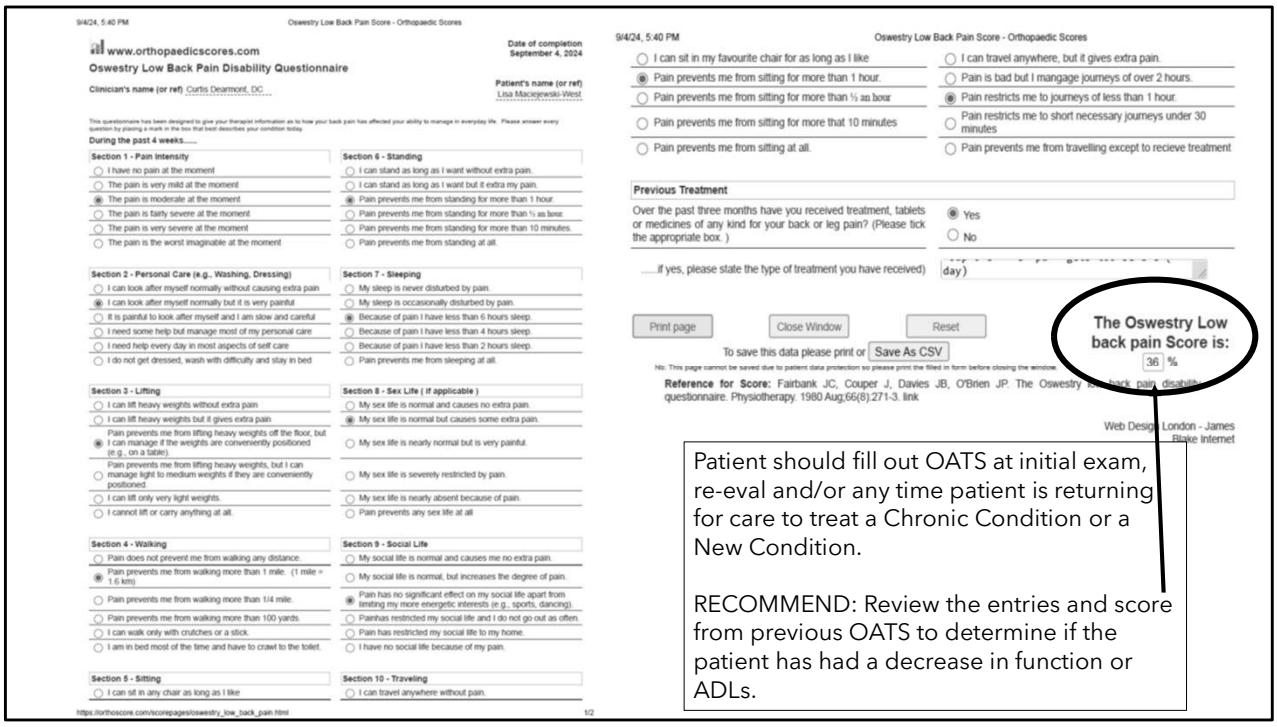
9/4/2024



9/4/24, 5:40 PM Oswestry Low Back Pain Score - Orthopaedic Scores

www.orthopaedicscores.com

Oswestry Low Back Pain Disability Questionnaire

Date of completion: September 4, 2024

Clinician's name (or ref): Curtis Dearmont, DC

Patient's name (or ref): Lisa Maciejewski-West

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the box that best describes your condition today.

During the past 4 weeks.....

Section 1 - Pain Intensity
- ○ I have no pain at the moment
- ○ The pain is very mild at the moment
- ◉ The pain is moderate at the moment
- ○ The pain is fairly severe at the moment
- ○ The pain is very severe at the moment
- ○ The pain is the worst imaginable at the moment

Section 2 - Personal Care (e.g., Washing, Dressing)
- ○ I can look after myself normally without causing extra pain
- ◉ I can look after myself normally but it is very painful
- ○ It is painful to look after myself and I am slow and careful
- ○ I need some help but manage most of my personal care
- ○ I need help every day in most aspects of self care
- ○ I do not get dressed, wash with difficulty and stay in bed

Section 3 - Lifting
- ○ I can lift heavy weights without extra pain
- ○ I can lift heavy weights but it gives extra pain
- ◉ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- ○ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ○ I can lift only very light weights
- ○ I cannot lift or carry anything at all.

Section 4 - Walking
- ○ Pain does not prevent me from walking any distance.
- ◉ Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km)
- ○ Pain prevents me from walking more than 1/4 mile.
- ○ Pain prevents me from walking more than 100 yards.
- ○ I can walk only with crutches or a stick.
- ○ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting
- ○ I can sit in any chair as long as I like
- ◉ I can sit in my favourite chair for as long as I like
- ○ Pain prevents me from sitting for more than 1 hour.
- ○ Pain prevents me from sitting for more than ½ an hour
- ○ Pain prevents me from sitting for more that 10 minutes
- ○ Pain prevents me from sitting at all.

Section 6 - Standing
- ○ I can stand as long as I want without extra pain.
- ○ I can stand as long as I want but it extra my pain.
- ◉ Pain prevents me from standing for more than 1 hour.
- ○ Pain prevents me from standing for more than ½ an hour.
- ○ Pain prevents me from standing for more than 10 minutes.
- ○ Pain prevents me from standing at all.

Section 7 - Sleeping
- ○ My sleep is never disturbed by pain.
- ○ My sleep is occasionally disturbed by pain.
- ◉ Because of pain I have less than 6 hours sleep.
- ○ Because of pain I have less than 4 hours sleep.
- ○ Because of pain I have less than 2 hours sleep.
- ○ Pain prevents me from sleeping at all.

Section 8 - Sex Life (if applicable)
- ○ My sex life is normal and causes no extra pain.
- ◉ My sex life is normal but causes some extra pain.
- ○ My sex life is nearly normal but is very painful.
- ○ My sex life is severely restricted by pain.
- ○ My sex life is nearly absent because of pain.
- ○ Pain prevents any sex life at all

Section 9 - Social Life
- ○ My social life is normal and causes me no extra pain.
- ○ My social life is normal, but increases the degree of pain.
- ◉ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., sports, dancing).
- ○ Painhas restricted my social life and I do not go out as often.
- ○ Pain has restricted my social life to my home.
- ○ I have no social life because of my pain.

Section 10 - Traveling
- ○ I can travel anywhere without pain.
- ○ I can travel anywhere, but it gives extra pain.
- ○ Pain is bad but I mangage journeys of over 2 hours.
- ◉ Pain restricts me to journeys of less than 1 hour.
- ○ Pain restricts me to short necessary journeys under 30 minutes
- ○ Pain prevents me from travelling except to recieve treatment

Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? (Please tick the appropriate box.)
- ◉ Yes
- ○ No

.....If yes, please state the type of treatment you have received) day)

Print page | Close Window | Reset

To save this data please print or Save As CSV

No: This page cannot be saved due to patient data protection so please print the filled in form before closing the window.

Reference for Score: Fairbank JC, Couper J, Davies JB, O'Brien JP. The Oswestry low back pain disability questionnaire. Physiotherapy. 1980 Aug;66(8):271-3. link

The Oswestry Low back pain Score is: 36 %

Web Design London - James Blake Internet

https://orthoscore.com/scorepages/oswestry_low_back_pain.html 1/2

Patient should fill out OATS at initial exam, re-eval and/or any time patient is returning for care to treat a Chronic Condition or a New Condition.

RECOMMEND: Review the entries and score from previous OATS to determine if the patient has had a decrease in function or ADLs.

AUDIT TEMPLATES

- Auditors may use various templates when reviewing medical records.
- Auditor will first check documents against the records request.
  - Did you send them everything they requested?
  - Did you send them more than they needed (irrelevant or not applicable to the audit)
- Auditor will check records against "Standard Documentation Requirements" first
- Auditor will check records against Industry Specific Requirements (ie: Medicare NCD/LCD/LCA)
- Auditor will confirm that the medical record supports the claim that was submitted

CHART AUDITING WORKSHEET
GENERAL DOCUMENTATION STANDARDS

GENERAL DOCUMENTATION STANDARD		PRESENT	NOT PRESENT	NOT APPLICABLE	NOTE
The medical record should be complete and legible					
The documentation of each patient encounter should include: the date; reason for the encounter; appropriate history and physical exam; review of lab, X-ray data and other ancillary services and, when appropriate, assessment; and a plan of care (including discharge plan, if appropriate)					
DATE					
REASON FOR THE ENCOUNTER					
APPROPRIATE HX AND EXAM					
REVIEW OF LABS					
REVIEW OF XRAY					
DOCUMENTED ANCILLARY SERVICES					
ASSESSMENT/DIAGNOSIS					
PLAN OF CARE					
Past and present diagnoses should be accessible to the treating and/or consulting physician					
The reasons for and results of X-rays, lab tests and other ancillary services should be documented or included in the medical record. In many records, the order and/or intent for the service to be performed is missing.					
Relevant health risk factors should be identified					

CHART AUDITING WORKSHEET
GENERAL DOCUMENTATION STANDARDS

GENERAL DOCUMENTATION STANDARD		PRESENT	NOT PRESENT	NOT APPLICABLE	NOTE
The patient's progress, including response to treatment, change in treatment, change in diagnosis and patient non-compliance should be documented.					
The written plan of care should include, when appropriate: treatments and medications, specifying frequency and dosage; any referrals; patient/family education; and specific instructions for follow-up					
The documentation should support the medical necessity of the patient evaluation and/or treatment, including thought processes and the complexity of medical decision-making					
All entries to the medical record should be dated and authenticated by physician/provider signature. Medical documentation with missing or invalid signatures fails to meet the CMS signature requirements and may result in claim denial.					
The CPT/HCPCS/ICD-10-CM codes reported on the Medicare claim should reflect the documentation in the medical record					

Medicare Documentation Job Aid for Chiropractic Doctors

Documentation Basics:
Chiropractic Documentation should include:

	Present	Not Present	N/A	Notes/Comments
Patient Information:				
Include the patient's name and date of service on all pages of documentation	☐	☐	☐	_____
Subluxation Documentation Requirements:				
Include documentation of subluxation shown by x-ray or physical exam	☐	☐	☐	_____
Include a CT scan and or MRI showing subluxation of spine	☐	☐	☐	_____
Include documentation of your review of the x-ray, MRI, or CT, noting level of subluxation	☐	☐	☐	_____
Include x-rays taken within 12 months before or 3 months following the beginning of treatment	☐	☐	☐	_____

Note - *In some cases of chronic subluxation (for example, scoliosis), Medicare may accept an older x-ray if the patient's health record shows the condition existed longer than 12 months and it's reasonable to conclude the condition is permanent*

OR

Include documentation of subluxation shown by physical examination. Documentation must show at least 2 elements of:				
Pain	☐	☐	☐	_____
Asymmetry/misalignment	☐	☐	☐	_____
Range of motion abnormality	☐	☐	☐	_____
Tissue tone changes (P.A.R.T.), including 1 that falls under asymmetry/misalignment or range of motion abnormality	☐	☐	☐	_____
Include dated documentation of the first evaluation	☐	☐	☐	_____
Include primary diagnosis of subluxation (including level of subluxation)	☐	☐	☐	_____
Include any documentation supporting medical necessity	☐	☐	☐	_____

Initial Evaluation:	Present	Not Present	N/A	Notes/Comments
History	☐	☐	☐	
Date of initial treatment	☐	☐	☐	
Description of current illness	☐	☐	☐	
Symptoms related to level of subluxation causing patient to seek treatment	☐	☐	☐	
Family history (recommended)	☐	☐	☐	
Past health history (recommended)	☐	☐	☐	
Mechanism of trauma (recommended)	☐	☐	☐	
Quality and character of symptoms or problem (recommended)	☐	☐	☐	
Onset, duration, intensity, frequency, location, and radiation of symptoms (recommended)	☐	☐	☐	
Aggravating or relieving issues (recommended)	☐	☐	☐	
Past interventions, treatments, medication, and secondary complaints (recommended)	☐	☐	☐	
Contraindications (for example, risk of injury to patient from dynamic thrust or discussion of risk with patient) (recommended)	☐	☐	☐	
Physical examination (P.A.R.T.)	☐	☐	☐	
Evaluation of musculoskeletal and nervous system through physical examination	☐	☐	☐	
Treatment given on day of visit (if relevant)	☐	☐	☐	
Include specific areas and levels of the spine that you manipulated	☐	☐	☐	
Medicare may cover treatment using hand-held devices. But Medicare doesn't offer more payment or recognize an extra charge for use of the device	☐	☐	☐	

Treatment Plan:				
Frequency and duration of visits (recommended)	☐	☐	☐	_____
Specific treatment goals (recommended)	☐	☐	☐	_____
Objective measures to evaluate treatment effectiveness (recommended)	☐	☐	☐	_____
Subsequent Visits:				
History	☐	☐	☐	_____
Review of chief complaint	☐	☐	☐	_____
Changes since last visit	☐	☐	☐	_____
System review, if relevant	☐	☐	☐	_____
Physical examination (P.A.R.T.)	☐	☐	☐	_____
Assessment of change in patient's condition since last visit	☐	☐	☐	_____
Evaluation of treatment effectiveness	☐	☐	☐	_____
Treatment given on day of visit (include specific areas and levels of spine that you manipulated)	☐	☐	☐	_____

These auditing templates will be used during the remainder of the class to review the Case Studies. They can be used also as self auditing tools for your own notes.

CASE STUDY 1 "MRS. BARR"

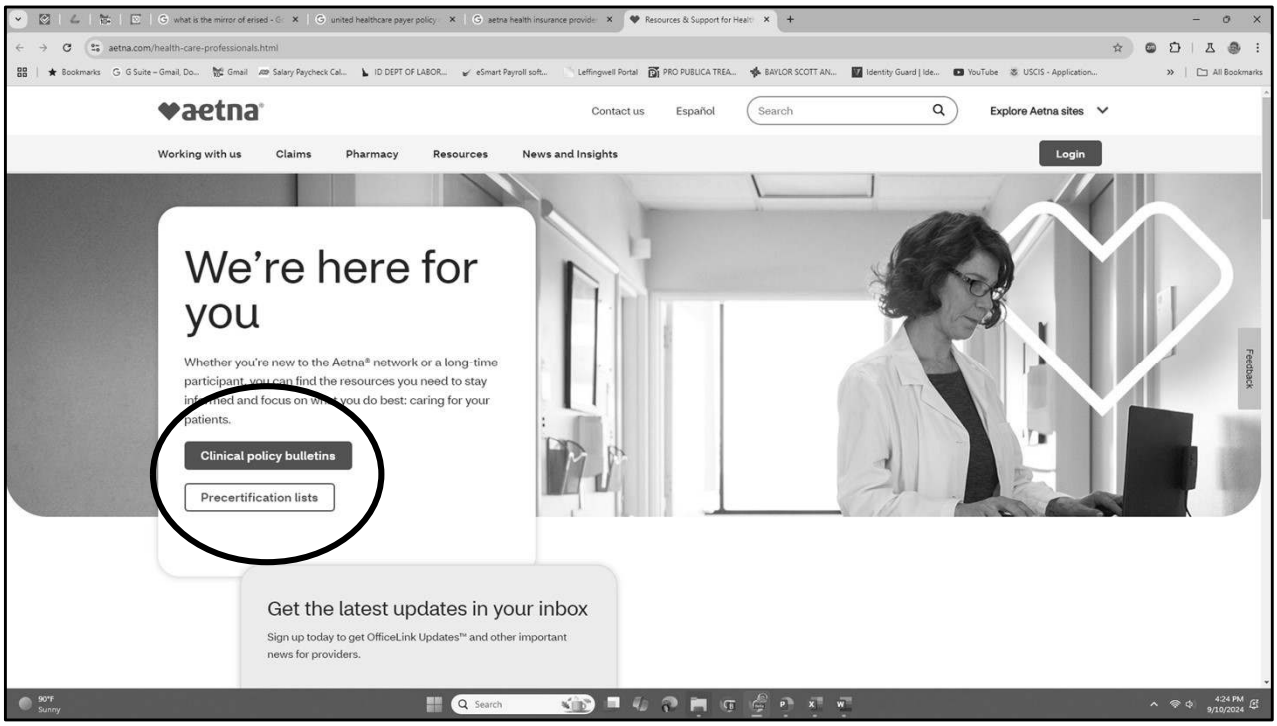
- ❑ 74 Y/O FEMALE, MEDICARE PATIENT (AS OF 10/1/21)
- ❑ 45 "AT" VISITS BETWEEN 10/1/21 THROUGH 5/1/24
- ❑ PROVIDER RECEIVED AUDIT REQUEST FROM MEDICARE
- ❑ DOCUMENT PACKET PROVIDED IS WHAT PROVIDER SENT TO MEDICARE

Questions – CASE 1

1. Did the provider meet all 10 of the "General Documentation Standards"? If no, what elements were missing?
2. Were bills accurately coded and did they accurately reflect the services provided **(as documented in the medical records)**; ?
3. Was Documentation completed correctly?
4. Were Services or items provided reasonable and necessary (by Medicare's Standards)?

CASE STUDY 2 “MS. MORROW”

- 33 Y/O FEMALE, COMMERCIAL INSURANCE (AETNA)
- ALL DOS’ AND CPT CODES INITIALLY APPROVED
- PAYER SENT REQUEST FOR AUDIT OF MEDICAL RECORDS
- DOCUMENT PACKET PROVIDED IS WHAT PROVIDER SENT TO PAYER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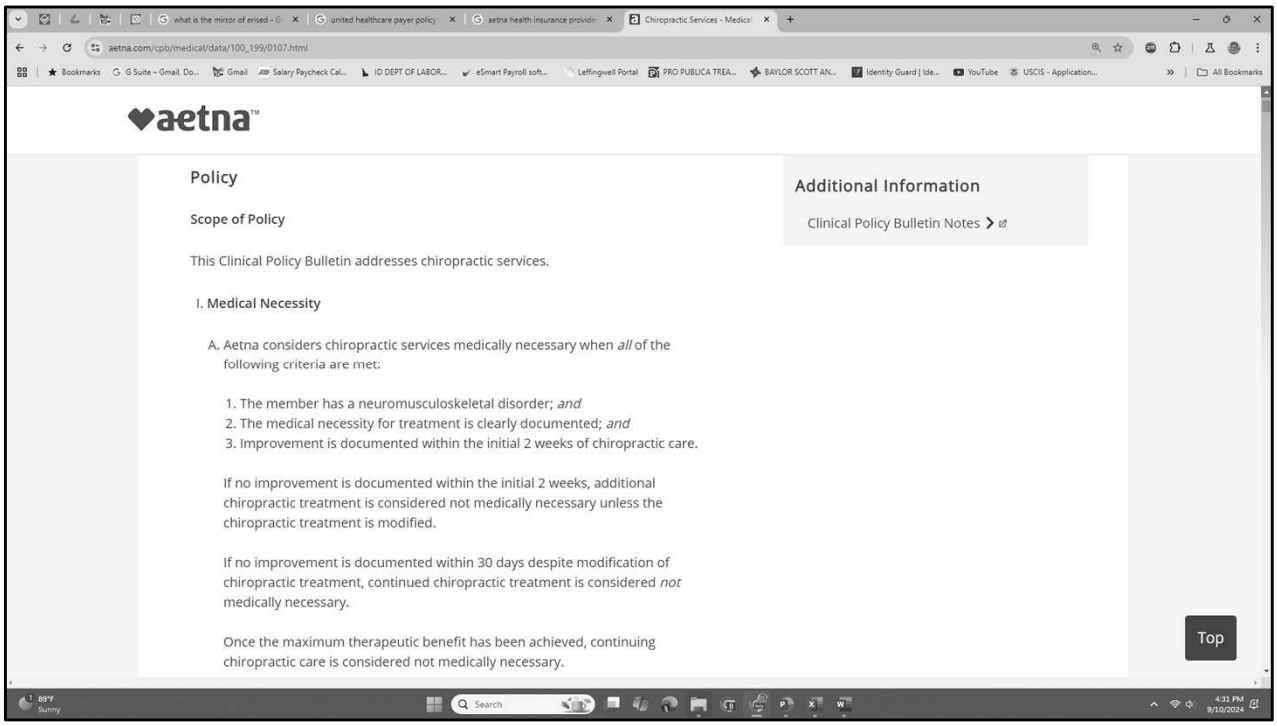
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aetna
Policy
Scope of Policy
This Clinical Policy Bulletin addresses chiropractic services.
I. Medical Necessity
A. Aetna considers chiropractic services medically necessary when all of the following criteria are met:
1. The member has a neuromusculoskeletal disorder; and
2. The medical necessity for treatment is clearly documented; and
3. Improvement is documented within the initial 2 weeks of chiropractic care.
If no improvement is documented within the initial 2 weeks, additional chiropractic treatment is considered not medically necessary unless the chiropractic treatment is modified.
If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is considered not medically necessary.
Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is considered not medically necessary.
Additional Information
Clinical Policy Bulletin Notes
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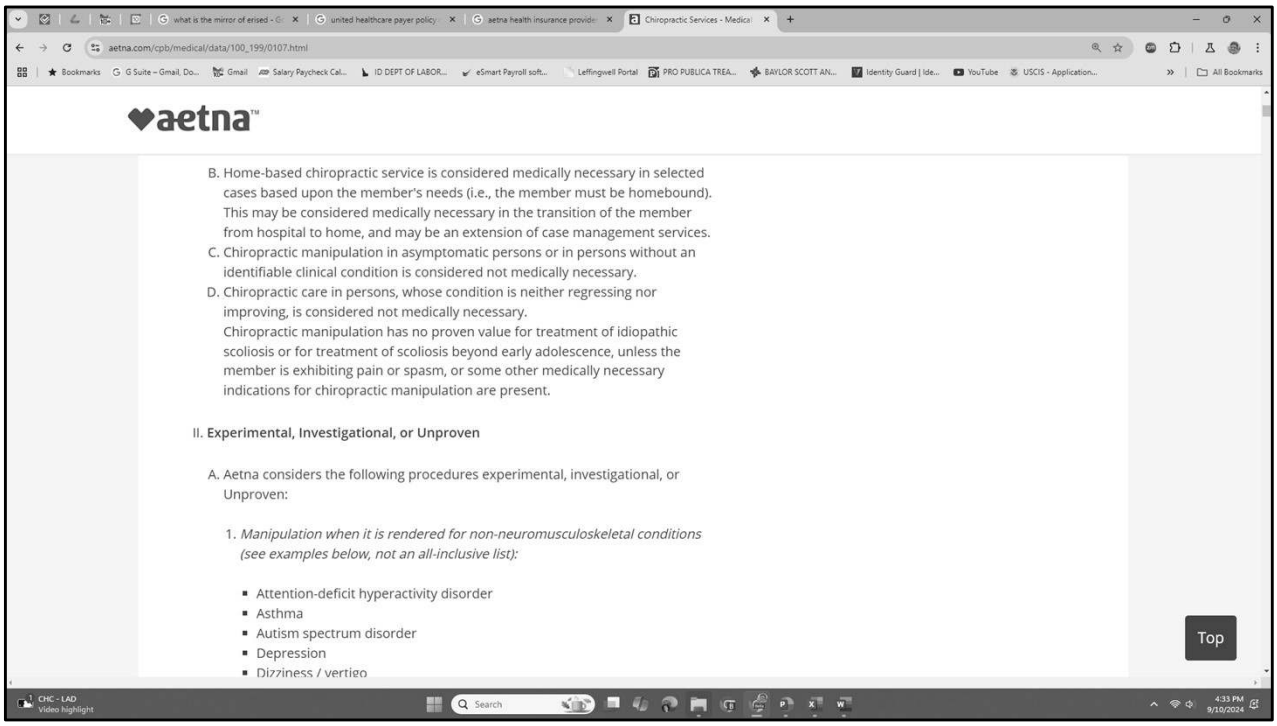
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B. Home-based chiropractic service is considered medically necessary in selected cases based upon the member's needs (i.e., the member must be homebound). This may be considered medically necessary in the transition of the member from hospital to home, and may be an extension of case management services.
C. Chiropractic manipulation in asymptomatic persons or in persons without an identifiable clinical condition is considered not medically necessary.
D. Chiropractic care in persons, whose condition is neither regressing nor improving, is considered not medically necessary.
Chiropractic manipulation has no proven value for treatment of idiopathic scoliosis or for treatment of scoliosis beyond early adolescence, unless the member is exhibiting pain or spasm, or some other medically necessary indications for chiropractic manipulation are present.
II. Experimental, Investigational, or Unproven
A. Aetna considers the following procedures experimental, investigational, or Unproven:
1. Manipulation when it is rendered for non-neuromusculoskeletal conditions (see examples below, not an all-inclusive list):
Attention-deficit hyperactivity disorder
Asthma
Autism spectrum disorder
Depression
Dizziness / vertigo
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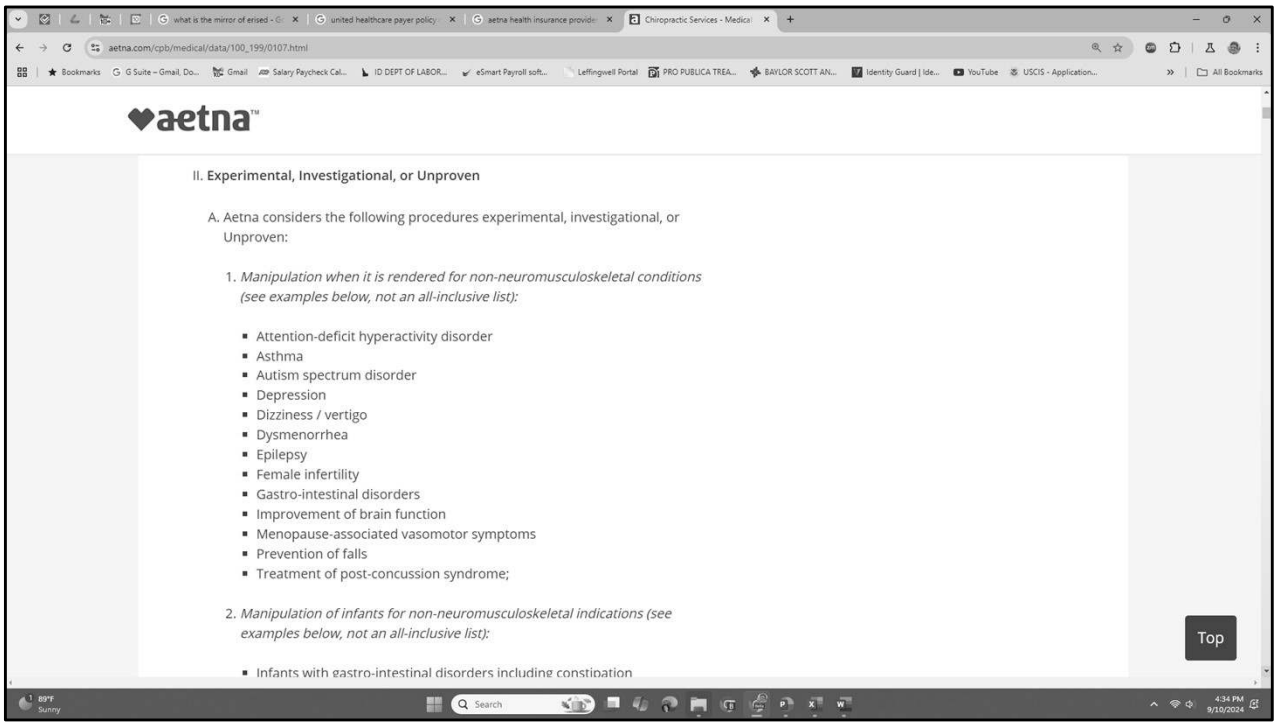
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II. Experimental, Investigational, or Unproven
A. Aetna considers the following procedures experimental, investigational, or Unproven:
1. Manipulation when it is rendered for non-neuromusculoskeletal conditions (see examples below, not an all-inclusive list):
Attention-deficit hyperactivity disorder
Asthma
Autism spectrum disorder
Depression
Dizziness / vertigo
Dysmenorrhea
Epilepsy
Female infertility
Gastro-intestinal disorders
Improvement of brain function
Menopause-associated vasomotor symptoms
Prevention of falls
Treatment of post-concussion syndrome;
2. Manipulation of infants for non-neuromusculoskeletal indications (see examples below, not an all-inclusive list):
Infants with gastro-intestinal disorders including constipation
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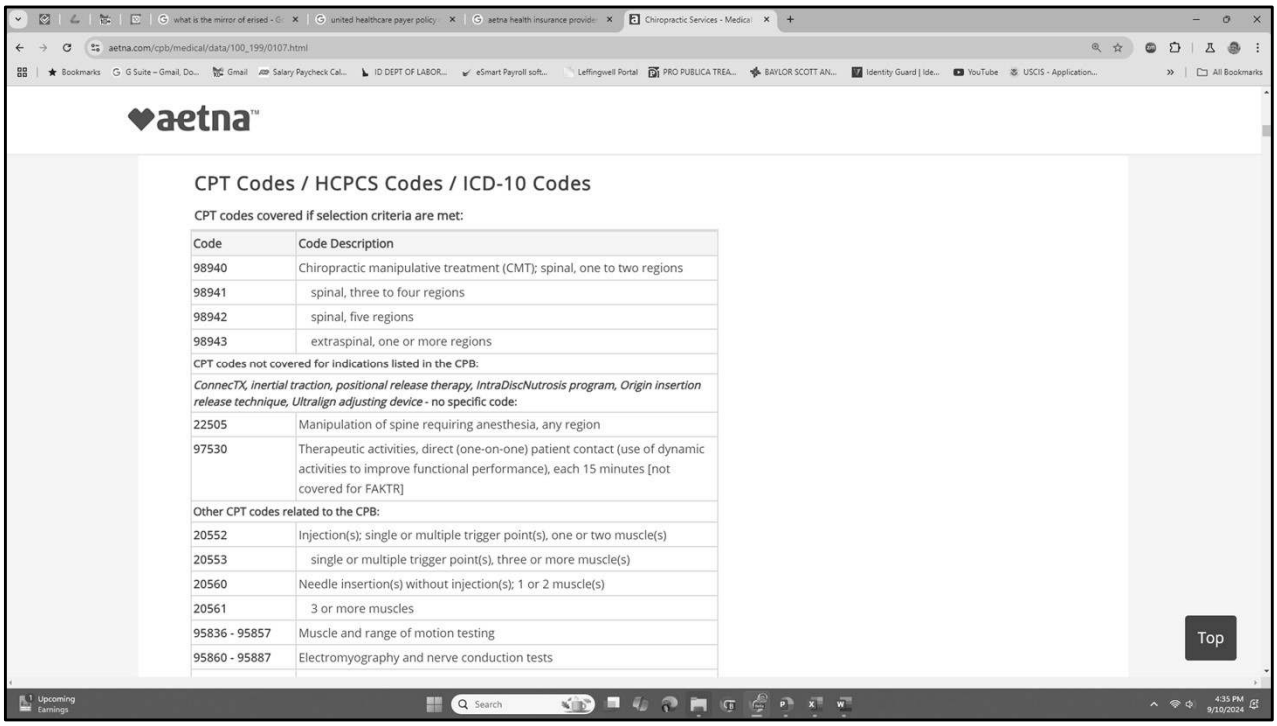
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CPT Codes / HCPCS Codes / ICD-10 Codes
CPT codes covered if selection criteria are met:
Code | Code Description
98940 | Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941 | spinal, three to four regions
98942 | spinal, five regions
98943 | extraspinal, one or more regions
CPT codes not covered for indications listed in the CPB:
ConnecTX, inertial traction, positional release therapy, IntraDiscNutrosis program, Origin insertion release technique, Ultralign adjusting device - no specific code:
22505 | Manipulation of spine requiring anesthesia, any region
97530 | Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes [not covered for FAKTR]
Other CPT codes related to the CPB:
20552 | Injection(s); single or multiple trigger point(s), one or two muscle(s)
20553 | single or multiple trigger point(s), three or more muscle(s)
20560 | Needle insertion(s) without injection(s); 1 or 2 muscle(s)
20561 | 3 or more muscles
95836 - 95857 | Muscle and range of motion testing
95860 - 95887 | Electromyography and nerve conduction tests
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Questions – CASE 2

1. Did the provider meet all 10 of the "General Documentation Standards"? If no, what elements were missing?
2. Name three elements from the General Documentation Standard that the provider did correctly
3. In this audit, the payer retrospectively denied the initial Date of service, and all 98943 and 97014 codes, and demanded a refund. What could the provider have done differently to prove medical necessity for these procedures?
4. The daily notes were SALTed. Did the provide modify the note enough to show that the services performed each visit were medically necessary?
5. The provider did not bill the payer for dry needling because it was considered "experimental/ investigational". After the audit, the payer demanded that the patient be refunded all the payments they made for the dry needling procedures. Why would they do that?

QUESTIONS?

CONCERNS?

NEED HANDOUTS?

NEED FORMS?

NEED ADVICE?

NEED HELP?

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