Proving Medical Necessity in *ANY* Type of Care

No Recording of ANY TYPE allowed

Mind expansion in process...

With Mario Fucinari, DC, CPCO, CPPM, CIC
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About Dr. Mario Fucinari, DC, CPCO, CPPM, CIC

- President, Ask Mario DC Consultants, LLC
- Certified Professional Compliance Officer (CPCO)
- Certified Physician Practice Manager (CPPM)
- Certified Insurance Consultant (CIC)
- Post-Graduate Faculty, Palmer College of Chiropractic, Logan College, Northeast College of Health Sciences (NYCC), Life West, NUHS, D'Youville College, Logan College, and Northwestern Chiropractic College
- Member, Medicare Carrier Advisory Committee
- National Speaker's Bureau for NCMIC, CHUSA and Foot Levelers
- Past Recipient Chiropractor of the Year

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Ask Mario

FOOT LEVELERS

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Standard of Care

"The type and level of care an ordinary, prudent, health care professional, with the same training and experience, would provide under similar circumstances in the same community."

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Medical Necessity

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of E&M service, when a lower level of service is warranted. The volume of documentation should *not* be the primary influence upon which a specific level of service is billed.

Medicare Carrier Manual Chapter 12, §30.6.1

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Medical Necessity

Documentation should support the level of service reported. The service should be documented during, or as soon as practicable, after it is provided in order to maintain an accurate medical record.

Medicare Carrier Manual Chapter 12, §30.6.1

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The *CONTENT* of Documentation

- Medical documentation is not about HOW MUCH you write; it is about WHAT you write.
- Coding is based on documentation. (not vice versa)
- Most providers are NOT paid enough, because they don't document everything they do.
- **If it is not documented, it never happened.**
- 33-52% of patient encounters are undercoded

(Journal of Family Medicine, 2001; 14:184-92, October 2003)

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The Rules of Documentation

- If it is not written, it never happened
- Use black or blue ink.
- Never use correction fluid or erase
- Correct errors by putting one line through it, write your correction, and initial the change.
- Be concise
- Be original
- Use only standard abbreviations
- Write legibly!
- Patient's name on all notes

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IS THE PURPOSE OF CHIROPRACTIC CARE?

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Title XVII of the Social Security Act, Section 1862 [a][1][a]

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

www.ssa.gov/OP_Home/ssact/title18/1862.htm

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BCBS Chiropractic Services Policy

goals and outcome measures for a new problem or a problem re-assessment. **(Plan)**

- A written plan of treatment relating to the type, amount, frequency, and duration of care is required for all patients. The plan of care must be updated as the patient's condition changes. A treatment plan is not valid for longer than 90 calendar days from the first treatment day under the certified treatment plan. The goal of the treatment plan should be to achieve functional improvements in the patient's condition. Specific treatment goals must be documented with anticipated time frames and objective measures to evaluate treatment effectiveness. Each complaint should be listed with selected treatment, duration, frequency, treatment goals, and objective measures to evaluate progress. The treatment plan should include the rationale for all services provided. A plan of care should be individualized for each patient. Documentation must support that each manipulation or treatment reported relates to a relevant symptomatic spinal and/or extraspinal region. Symptoms must bear a direct relationship to the level of subluxation cited. Documentation of "pain" is not sufficient; the location of pain or condition must be described. **(Plan of Care)**
- Signature requirements- Each medical record must be signed and dated by the clinician

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Red Flag: Not Updating Box 14

- When did you first begin treating the patient?
- Has there been a NEW injury or an exacerbation?

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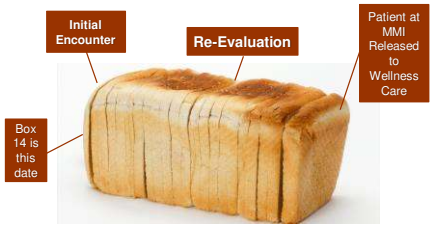

EPISODE OF CARE

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Medical Necessity

For any item to be covered by Medicare, it must

1) be eligible for a defined Medicare benefit category,
2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
3) meet all other applicable Medicare statutory and regulatory requirements.

CMS Pub. 100-03, (Medicare National Coverage Determinations Manual), Chapter 1, Section 40.2

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Medical Necessity

OATS

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 condi (Medicare does not pay for pain).**

Treatment Goals

2. **You must have a reasonable <u>expectation</u> of recovery or improvement of function.**

P.A.R.T.

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**

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Medicare 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**.

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Medical Necessity

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

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Medical Necessity

Maintenance Therapy NEW

- **Once MMI has been reached, Medicare will NOT pay for maintenance or supportive care.**
  - 1. Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or 2. 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.

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The Universal Initial Report

- Status of the patient
  - New : Never seen before or not in the last three years
  - Established: Patient seen by you or other doctors in your group of the same specialty, within the last three years
- Chief Complaint (cc)
- PFSH – Past, Family, Social History
- Review of Systems (ROS)
- HPI: L, M, N, O, P, Q, R, S, T
- Dx
- Treatment Plan
- Signature

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Medicare Initial Encounter Report

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

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Medicare Initial Encounter Report

- **Q**uality and character of symptoms/problem
- **R**adiation of symptoms
- **S**everity
- **T**ime

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Medicare Initial Encounter Report

Treatment Plan

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

Date of Initial Treatment (Box 14)

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The History – Chief Complaint

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

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The History – Chief Complaint

- Symptoms causing patient to seek treatment (Chief Complaint)
  - Where, What, How, When and Why?
  - What brought the patient in? What is the cause? (Mechanism of injury)
    - Acute injury/trauma? If patient denies something, document it.
    - Chronic condition…why now?
- In Medicare, trace it back to a certain vertebra. This needs to be declared in an "Initial Visit Report."
- Prior level of *function.* What are the changes in *function?*
- Ask the questions to better define what is the complaint of the patient.

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The Personal Injury Consultation

- Obtain a police report, whenever possible, to verify the injury
- Mechanism of injury?
- Direction of force?
- Preparedness for impact

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The Personal Injury Consultation

- What position in the auto were you?
  - Driver? Passenger?
- Document care obtained after the accident
- Home care?
- Progression of pain since the accident
- L, M, N, O,P,Q,R,S,T for each complaint region

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Is There a Causal Connection?

Causal Connection - a relationship between two events. One event causes the other.

- The physician must document is there is a causal connection of the symptoms to the mechanism of trauma.
- Establish a baseline of symptoms prior to the injury and work to achieve "pre-accident status."

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Mechanism of Injury

- Front, Rear, or Lateral Impact?
- Lateral Impact
  - Vehicular Damage ≠ Bodily Injury
- Seat Belts? Seat Reclined? Air Bags? Head Rest?
- Position of the Head?

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The Personal Injury Consultation

Automobile cases typically use the Colossus® software program or other variations.

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The Personal Injury Consultation

****Duties under Duress**

- This area acknowledges the painful or difficult activities of daily living not otherwise reported. This is described as pain while performing an activity.

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The Worker's Compensation Consultation

- What happened?
  - Mechanics of the injury
  - The injury *must* occur "in the course of normal work duties"
- Date of onset
- Time of onset
- Who did they report the injury to?
- Who did they receive medical care from? Factory nurse?
- TTD?

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Evidence Based
Outcomes Assessment Tools (OATs)

(*Functional Impairment Rating*)

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Why Outcomes Assessment?

- An ***objective*** measure of the patient's **ADL** 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)

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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.

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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

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SCAT5 for mTBI or Post-COVID

- The SCAT5 is a standardized tool for evaluating concussions designed for use by physicians and licensed healthcare professionals. The SCAT5 cannot be performed correctly in less than 10 minutes.
- Any athlete with suspected concussion should be REMOVED FROM PLAY, medically assessed and monitored for deterioration. No athlete diagnosed with concussion should be returned to play on the day of injury
- The diagnosis of a concussion is a clinical judgment, made by a medical professional. The SCAT5 should NOT be used by itself to make, or exclude, the diagnosis of concussion. An athlete may have a concussion even if their SCAT5 is "normal".

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Revised Oswestry

Functional Disability Score

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

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Neck Pain Disability Index Score

0-8 = None
10-28% = Mild
30-48% = Moderate
50-68% = Severe
>70% = Crippled

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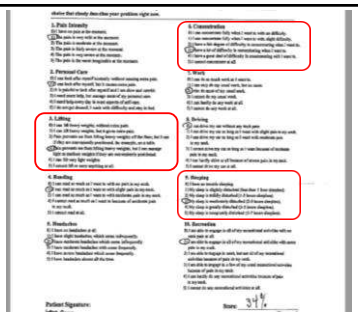
Neck Pain Disability Index



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OATS ⟶ Tx Goals

FOOT LEVELERS

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Outcome Assessment Tests (OATs)

To be significant, the outcome assessment test must have a minimum reduction of a 30% in score between the initial exam and the re-exam to be <u>clinically significant</u>.

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E/M Guidelines
2024

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Selecting the Appropriate Level of E/M

Medical Decision Making (MDM)

- Number and complexity of problems addressed
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

OR

Time

- Total time (face-to-face and non-face-to-face)

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MDM and the NEW Guidelines

Medical Decision Making is defined as the process of establishing diagnoses, assessing the status of a condition, and/or selecting a management option.

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Use Technology to Reduce Time in the Office

- *Clerical staff* updates their insurance information
- Consider using telephone or video to pre-screen patients
- Schedule the patient for their *virtual* consultation appointment
- *Clinical staff* records the patient's chief complaint(s),history, new injuries, flare-ups, surgeries, medications, loss of function.
- Clinical staff alerts the Clerical staff to obtain past records
- Any work the clinical staff does, the doctor reviews the information **on the day of the examination appointment. That information gained goes into the Medical Decision Making (MDM) element.**

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Two of the three elements must be met to determine the code

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Me		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test	Low risk of morbidity from additional diagnostic testing or treatment

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Level of MDM (Based on 2 out of the 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
Low 99203 99213	Low ■ 2 or more self-limited or minor problems; ■ 1 stable, chronic illness; ■ 1 acute, uncomplicated illness or injury; ■ 1 stable, acute illness; ■ 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (1 out of 2 categories) Category 1: Tests and documents ■ Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment

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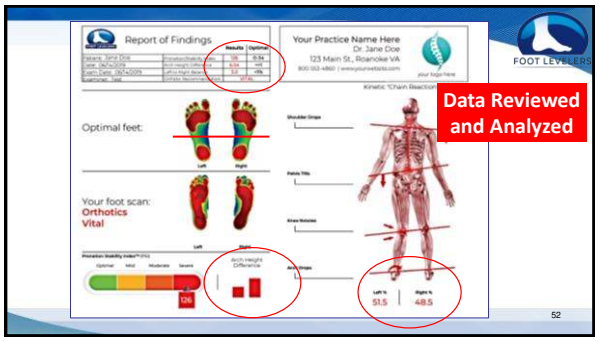

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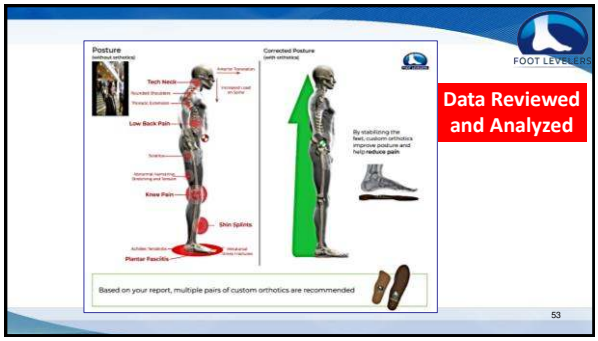

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TAKE THEIR ***COMPLETE*** VITALS



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99204/99214 MDM

Level of MDM (Based on 2 out of the 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
Moderate **99204** **99214**	Moderate ▪ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; ▪ 2 or more stable, chronic illnesses; ▪ 1 undiagnosed new problem with uncertain prognosis; ▪ 1 acute illness with systemic symptoms; ▪ 1 acute, complicated injury	Moderate (1 out of 3 categories) Category 1: Tests and documents ▪ Any combination of 3 from the following: ▪ Review of prior external note(s) from each unique source*; ▪ Review of the result(s) of each unique test*; ▪ Ordering of each unique test* ▪ Assessment requiring an independent historian(s) Category 2: Independent interpretation of tests Category 3: Discussion of management or test interpretation	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: ▪ Prescription drug management ▪ Decision regarding minor surgery with identified patient or procedure risk factors ▪ Decision regarding elective major surgery without identified patient or procedure risk factors ▪ Diagnosis or treatment significantly limited by social determinants of health

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NEW 2024 Time Calculations

ONLY FOR OUTPATIENT SERVICES

CODE	TIME in Minutes
99201	Code Deleted
99202	Must meet or exceed 15
99203	Meet or exceed 30
99204	Meet or exceed 45
99205	Meet or exceed 60
99211	Time Removed
99212	Meet or exceed 10
99213	Meet or exceed 20
99214	Meet or exceed 30
99215	Meet or exceed 40

PRE-SERVICE + SERVICE + POST-SERVICE = *TOTAL* TIME

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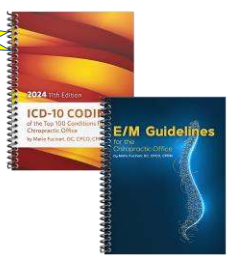
NEW!



ALL NEW 2024 E/M GUIDELINES AND ICD-10 2024 EDITION MANUAL BUNDLE USE PROMO CODE BUNDLEIT FOR DISCOUNT PRICE ON CHECKOUT

www.Askmario.com

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Re-Examination

- A formal re-examination should be done "to determine progress and need for further care" on EVERY PATIENT IN ACTIVE CARE **(RISK MANAGEMENT)**
- Should be done every 10-15 visits or every **30**-45 days. *RECOMMENDED EVERY 30 DAYS*

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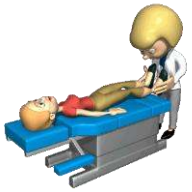
The Re-Examination

A re-examination should include

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



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

- –Any change in diagnosis
- –Treatment frequency/schedule
- –Treatment goals
- –Restrictions
- –Referrals or further tests
- –Exercise/rehabilitation

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UNIVERSAL SOAP NOTE TEMPLATE

Subjective
- Give chief complaint(s) as described by the patient that day.
- Give pain levels for each region being treated.
- Describe any functional improvement. This goes to reaching the treatment goals.

Objective
- Give all palpatory findings
- Repeat AROM, orthopedic, and neurologic tests *as indicated*

Assessment
- The assessment shows the medical necessity for care. It is comparable to Medical Decision Making. You want to indicate how the patient is improved and why they still need care. *Example: The patient is improved with decreased arm pain and decreased edema, but still has subluxation and spasms at C7.*

Plan
- Document the segments adjusted, the technique used, and the patient's reaction to treatment. *Example: CMT C1, T3, T7, L5, and Right SI Diversified, Patient tolerated treatment without incident.* This is very important for risk management.

Signature: Either hand sign or electronic signature. Should have name of provider and credentials. Preferred to have time and date stamp.

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The SOAP Note Subjective Portion (S)

Subjective – What's going on?

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The SOAP Note Subjective Portion (S)

- 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.

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- Subjective – What's going on?
- Objective – What did you find?

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The SOAP Objective (O)

- 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.

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The Medicare SOAP Note

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

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

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

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

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The Medicare SOAP Note

III. Evaluation of treatment effectiveness

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

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

- **You must document the actual segments that you adjusted.**
- **Document the response to the adjustment. "patient tolerated treatment without incident"**

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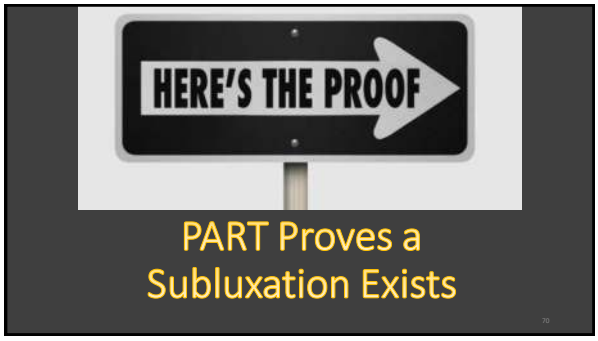

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P.A.R.T.

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

PART

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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.

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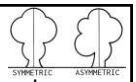
P.A.R.T.



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.

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P.A.R.T.

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

   Tissue, tone changes using descriptions pertaining to the characteristics of **contiguous, or associated soft tissues (with the spine)**, 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.

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General Questions

- **Subjective** – What's going on?
- **Objective** – What did you find?
- **Assessment** – What do you think?

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General Questions

- **Subjective** — History
- **Objective** — Exam
- **Assessment** — MDM

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The SOAP Note Assessment (A)

- 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.

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Answer the Questions

How is the patient improved?

What have you accomplished so far?

Why does the patient still need care?

What do you want to accomplished now?

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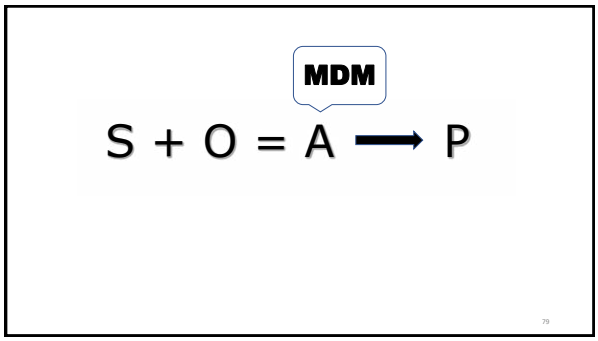

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A: The patient has improved with decreased pain, spasms, and edema. They have no further sleep disturbance due to pain. The patient still has intolerance to ADLs and instability due to deconditioning.

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A: The patient has improved with decreased sleep disturbance and was able to stand for 30 minutes without pain. They still have weakness of the right piriformis and gluteals causing instability of the right SI region with walking and sitting.

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General Questions

- **Subjective** – What's going on?
- **Objective** – What did you find?
- **Assessment** – What do you think?
- **Plan** – What are you going to do about it?

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Treatment Plan

A. Frequency and duration
B. Treatment Goals
C. Care Plan

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Treatment Goals *Must* Address ***Function***

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General Treatment Goals

As time progresses, the short-term goals progress until finally they catch up with the long-term goals.

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Mario's Law of Biomechanics

Faulty Mechanics → Mechanical Faults

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RECENT AUDIT FINDINGS LEADING TO AN *ATTEMPTED* $600,000 RECOUPMENT

patient's progression of care with ongoing chiropractic treatment. The Contractor based their decision on LCD L34009; Section 1862(a)(1)(A) of the Social Security Act; 42 Code of Federal Regulations (CFR) 411.15(K)(i); IOM Publication 100-02, Chapter 15, Sections 240.1.2(B) and 240.1.3; Medicare Learning Network (MLN) Matters Number SE1101.

Upon reconsideration, it has been determined that payment cannot be allowed for the chiropractic spinal manipulative treatment at issue. In this instance, the claim was billed with the diagnosis of thoracic subluxation (M99.02). The treatment note for the date of service indicates the treatment was rendered at the levels of T5, T6, L3, left pelvis, sacrum, and C2. This note further documents the patient's diagnoses of cervical subluxation (M99.01), lumbar subluxation (M99.03), sacral subluxation (M99.04), and pelvic subluxation (M99.05). The note also documents the patient's progress of care with the ongoing chiropractic treatment. In addition, the plan of care documents the recommended duration and frequency of treatments. However, the plan of care does not document the specific goals of treatment or objective measures to evaluate treatment effectiveness. Therefore, payment cannot be allowed for the chiropractic spinal manipulative treatment at issue, in accordance with LCD L34009.

The decision of the QIC is unfavorable.

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Short – Term Goals (First 2-3 weeks)

1. **Decrease pain, spasms, edema and increase range of motion**
2. Resolution of any radicular pain in the lower extremity
3. Patient will be able to sleep in bed without pain for 6-8 hours.
4. Patient will be able to tie shoes without pain in 2 weeks
5. Independent with basic self-care ADL such as bathing without increased low back pain

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Long – Term Goals (4-6 weeks)

1. Low back pain at worst less than or equal to 4/10 with all activities
2. Patient will ambulate 15 minutes at 2.0 miles per hour without increased low back pain
3. Bilateral hip flexion, multifidus and gluteal strength from 4+ to 5/5
4. Patient will be able to stand for 20 minutes or longer without pain in 4 weeks
5. Patient will demonstrate an improvement on their OATS score of >30% in 4 weeks
6. **To prepare the patient for a home-based exercise program**

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MDM

S + O = A ⟶ P

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Proving Medical Necessity

- Analyzing the Subjective and the Objective data, you arrive at a Differential Diagnosis (DDX)
- Rule In or Rule Out by using the TOOLS available to you.
- Foot Levelers KIOSK yields an analysis of the KINETIC CHAIN
- What other Pathology or Biomechanical Changes are you missing?
- Put the pieces together

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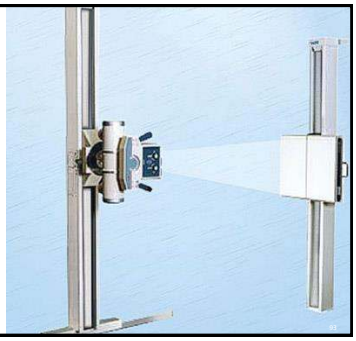
Do You Own an X-ray Machine?

Policies and Procedures must be in place to obtain imaging reports, if available, *prior* to consultation.



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Degenerative Disc Disease

DDD over the entire spine was 90% in men and women aged >50 years

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HEDIS® Requirements for the Use of X-rays with Low Back Pain

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HEDIS® LBP IMAGING

- Imaging of for uncomplicated lower back pain is not indicated for the first 28 days of care unless a specific exclusion exists.
- Documentation of the following can exclude the member from the 28-day waiting period:
- Cancer, malignant neoplasm, HIV or major organ transplant any time prior to or within 28 days after the imaging study.
- Recent trauma within 90 days prior to or within 28 days after the imaging study.
- Spinal infection, neurologic impairment or IV drug abuse within one year prior to or within 28 days after the imaging study.
- Neurologic impairment within one year prior to or within 28 days after the imaging study.

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A NEW TWIST ON ICD-10 CODING

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BCBS Guidelines on Imaging for LBP

Partial List

- M47.816 Spondylosis without myelopathy or radiculopathy, lumbar region
- M54.16 Radiculopathy, lumbar region
- M54.30 Sciatica, unspecified side
- M54.50 Low back pain, unspecified
- M54.59 Other low back pain
- M54.9 Dorsalgia, unspecified
- M99.83 Other biomechanical lesion of the lumbar region
- S33.6xxA Sprain of SI joint, initial encounter
- S39.012D Strain of muscle of lower back, subsequent encounter
- S39.92Xs Unspecified injury of lower back, sequela

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BCBS Guidelines on Imaging for LBP

Exclusions: There are several categories or reasons that will remove the case from the LBP HEDIS measure if the imaging is done within the first 28 days of the diagnosis, because a medical need Those include:

- Cancer
- Neurologic impairment
- Spinal infection
- Recent Trauma

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Exclusion List for Imaging of the LBP

Exclude any member who has had a diagnosis for which imaging is clinically appropriate. Any of the following will meet the criteria:

- **Cancer:** any time in the member's history through 28 days after the episode start date.
- **Recent trauma:** any time during the 90 days prior to the episode start date through 28 days after.
- **IV Drug abuse:** any time during the 12 months prior to the episode start date through 28 days after.
- **Neurologic Impairment:** any time during the 12 months prior to the episode start date through 28 days after.
- **HIV:** any time in the member's history through 28 days after the episode start date.
- **Spinal infection:** any time during the 12 months prior to the episode start date through 28 days after.
- **Major organ transplant:** any time in the member's history through 28 days after the episode start date.
- **Prolonged use of corticosteroids:** 90 consecutive days of corticosteroid treatment any time during the 12 months prior to and including the episode start date. Examples of corticosteroid treatment medications are Hydrocortisone, Cortisone, Prednisone, Prednisolone, Methylprednisolone, Triamcinolone, Dexamethasone, and Betamethasone.

Exclude members in hospice from the eligible population for this measure.

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Exclusions from LBP HEDIS

Cancer – there are 1,484 diagnosis codes for cancer active now or a personal history of cancer any tune during the patient's lifetime. Some common diagnosis codes are:

- Z85.9 Personal history of malignant neoplasms, unspecified (any cancer)
- Z86.03 Personal history of neoplasm of uncertain behavior (any cancer)
- Z85.3 Personal history of malignant neoplasm of the breast
- Z85.40 Personal history of malignant neoplasm of unspecified female genital organ (cervix, uterus, ovary, etc.)
- Z85.45 Personal history of malignant neoplasm of unspecified male genital organ (prostate, testicular, etc.)
- Z85.820 Personal history of malignant melanoma of the skin

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Exclusions from LBP HEDIS

Neurologic impairment – there are five diagnosis codes for impairment any time during the 12 months prior to the diagnosis. Two common codes are:

- R26.2 Difficulty in walking, not elsewhere classified
- R26.89 Other abnormalities of gait and mobility

  Includes: Gait disorder, painful gait
  Gait disorder, weakness
- R29.2 Abnormal reflex

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Exclusions from LBP HEDIS

Spinal infection – there are 13 diagnosis codes for infection any time during the 12 months prior to the diagnosis. Two common codes are:

- M46.46 Discitis, unspecified, lumbar region
- M46.36 Infection of the intervertebral disc (pyogenic), lumbar region

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Exclusions from LBP HEDIS

Recent trauma – there are 19, 255 diagnosis codes for trauma up to 90 days prior to the diagnosis. One generic trauma code is:

- G89.11 Acute pain due to trauma

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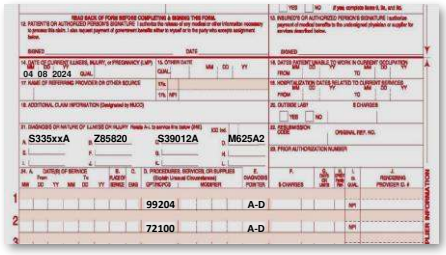
EXAMPLE HEDIS® MEASURE CLAIM FORM



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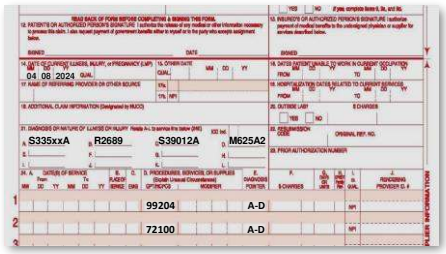
EXAMPLE HEDIS® MEASURE CLAIM FORM



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Further Resources

- NCQA www.NCQA.org/
- NCQA HEDIS LBP Technical Specifications
  https://www.ncqa.org/hedis/measures/

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The Importance of the Diagnosis

When a diagnosis is accurate and made in a timely manner, a patient has the best opportunity for a positive health outcome because clinical decision making will be tailored to a correct understanding of the patient's health problem.

Holmboe ES, Durning SJ. Assessing clinical reasoning: Moving from in vitro to in vivo. Diagnosis. 2014;1(1):111–117.

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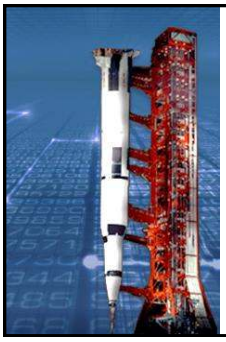

Is Your Coding Doomed?

- Increased Specificity in ICD-10
- Increased Detail in Documentation
- Code to the Highest Level of Specificity

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Anchoring Bias in Diagnosis

The focus on a single—often initial—piece of information when making clinical decisions without sufficiently adjusting to later information.

Ly DP, Shekelle PG, Song Z. Evidence for Anchoring Bias During Physician Decision-Making. *JAMA Intern Med.* 2023;183(8):818–823. doi:10.1001/jamainternmed.2023.2366

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ICD-10-CM Rules

Mario Rule #2: Code what you know

Codes that describe symptoms and signs are only acceptable if that is the highest level of diagnostic certainty documented by the doctor. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established.

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ICD-10-CM Rules

Signs and symptoms that are associated routinely with a disease (**condition)** process **should not** be assigned as additional codes, unless otherwise instructed by the classification.

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ICD-10-CM Rules

Code all documented conditions that coexist at the time of the visit that REQUIRE OR AFFECT patient care. Do not code conditions that no longer exist.

Co-morbidity or complicating factors

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ICD-10-CM Rules

Do NOT code for unconfirmed diagnoses that are probable, suspected, to rule out, etc.

- If you suspect it, document it, but do not put it as a diagnosis on the claim form if it is not confirmed.

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Care Plan

What are you going to do and why?

116

The Care Plan

- Care plans are a way to strategically approach and streamline the treatment process.
- It offers effective communication between all parties (doctors, staff, and insurers).
- A care plan helps team members organize aspects of patient care according to a timeline.
- For patients, having clear goals to achieve will make them more involved in their treatment and recovery.

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Care Plan

- In the acute stage (first two weeks): manipulation, EMS (unattended), ice, pulsed ultrasound, custom-molded orthotics, and further patient education as indicated
- In the sub-acute stage (two weeks to three months): manipulation per palpation, skilled therapeutic rehabilitation exercise to improve functional capacity, strength and endurance and to decrease pain with ADL and further patient education as indicated

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Therapeutic Modalities and Rehabilitation

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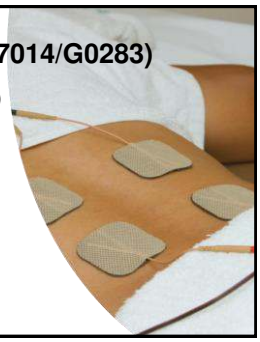
Electric Stimulation (97014/G0283)



EMS - High Volt Therapy (HVT)

- Rationale
  - Pain relief
  - Reduction of Spasms
  - Decrease edema
  - Improve tissue healing

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RATIONALE FOR ELECTRIC MUSCLE STIMULATION CPT Code 97014/G0283

97014 Application of modality to one or more areas electrical stimulation
G0282 HCPCS Medicare Application of modality to one or more areas electrical stimulation

As a policy in our office, electric muscle stimulation (97014 or G0283) is an unattended therapy, performed under the delegation of duties. It is our policy that this therapy is to be done with a treatment time of a minimum of ten minutes.

Electric stimulation therapy is a therapeutic treatment that applies electrical stimulation in treating muscle spasms and pain. It can help prevent atrophy and build strength in patients with chronic injuries. It is used to decrease pain, increase muscle metabolism, increase blood flow, release muscle spasms, and reduce healing time. Since the cases are involving a chronic subluxation condition, the goal of the therapy is to prevent, or reverse skeletal muscle wasting and therefore improve function in activities of daily living.

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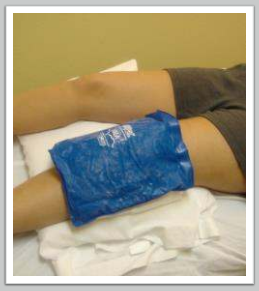

ICE (COLD) PACKS

- Decreases swelling/edema
- Stops the body's reaction to injury
- R.I.C.E.
- Decreases nerve, joint, or muscle pain

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HEAT PACKS

- Increases circulation
- Decreases spasms
- Decreases pain

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Ultrasound

Indications:

- Joint pain and edema, and tendon attachment.
- Cleans out the "gunk."
  - Exudate is fluid that leaks out of blood vessels into nearby tissues. The fluid is made of cells, proteins, and solid materials. Exudate may ooze from cuts or from areas of infection or inflammation. It is also called pus.
- Dangerous – can BURN the Bone.
- Continuous Mode – Heat producing
- Pulsed Mode – Non-heat producing

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Mechanical Traction (CPT 97012)

97012 Application of a modality to one or more areas traction mechanical

Therapeutic modality mechanical traction one or more areas was **used to increase range of motion and flexibility and to decrease adhesion formation of adjoining tissues**. The procedure utilizes a roller table type traction that applies sustained or intermittent mechanical autotraction that uses the body's own weight to create the force. The mechanical traction produces a force producing a distraction between the vertebrae or joints, thereby relieving pain and increasing tissue flexibility. The health care provider provides supervision for the service. The treatment time is 12-15 minutes.

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Trigger Point Documentation

A Trigger Point (TrP) is a hyperirritable spot, a palpable nodule in the taut bands of the skeletal muscles' fascia. Direct compression or muscle contraction can elicit jump sign, local tenderness, local twitch response and referred pain which usually responds with a pain pattern distant from the spot.

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Trigger Point Documentation

- **Jump sign** is the characteristic behavioral response to pressure on a TrP. Individuals are frequently startled by the intense pain. They wince or cry out with a response seemingly out of proportion to the amount of pressure exerted by the examining fingers. They move involuntarily, jerking the shoulder, head, or some other part of the body not being palpated. A jump sign thus reflects the extreme tenderness of a TrP.
- **Jump sign has been considered pathognomonic for the presence of TrPs.**

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Trigger Point Documentation

Referred pain, also called reflective pain, is pain perceived at a location other than the site of the painful stimulus. Pain is reproducible and does not follow dermatomes, myotomes, or nerve roots. There is no specific joint swelling or neurological deficits. Pain from a myofascial TrP is a distinct, discrete and constant pattern or map of pain with no gender or racial differences able to reproduce symptoms

Source: *The Concise Book of Trigger Points*, by Simeon Niel-Asher, Third Edition.

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Manual Therapy Techniques Rationale - CPT Code 97140

Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction, or trigger point therapy), 1 or more regions.

The 97140 CPT code treatment of the restricted motion of soft tissues involving the extremities, trunk, or neck. **Soft tissue mobilization through manipulation.** Skilled manual techniques (active and/or passive) are applied to muscles, soft tissue, ligaments, and fascia to effect changes in the soft tissues, articular structures, neural or vascular systems. Examples are the facilitation of fluid exchange, restoration of movement in acutely edematous muscles, or stretching of shortened connective tissue.

Due to the patient's subjective and objective findings, the patient demonstrated the following restrictions, negatively impacting the patient's quality of life. (List the purpose of the services, such as facilitating fluid exchange, restoring movement in acutely edematous muscles, increasing range of motion of the joints, or stretching of shortened connective tissue.

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Functional

Rehabilitation

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Disc Rehabilitation Therapy

- 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.

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Rehabilitation Therapy

Every rehabilitation program must start with an assessment of abnormal function (strength, endurance, coordination, balance and flexibility)

The quantifiable functional deficit is the baseline from which to determine progress

Ask the patient, "What can you NOT do?"

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Rehabilitation Therapy

- The physician or therapist is required to have direct one-on-one patient contact.
- DOCUMENT WHO ATTENDED
- The patient must perform the rehab exercises while the doctor instructs, oversees, and corrects the biomechanics.
- The codes for rehab services are based on 15-minute intervals.

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TriFlex

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97110 Therapeutic Exercises

- **97110 is used when the treatment goals are to increase strength, endurance, functional capacity, range of motion, and/or flexibility.**
  - Treadmill (endurance), Isokinetic exercises for ROM (weights or theraciser), Lumbar stabilization exercises (flexibility), Gymnic ball (stretching or strengthening)
  - Documentation must show objective loss of range of motion, strength or mobility.

Rationale

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Deconditioning Syndrome

"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. © 2007, Pg. 7

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The Rationale of Medical Necessity

History

- Mechanism of injury?
- Functional Loss

Documentation (S + O)

Diagnosis

Rationale (MDM)

Treatment Plan

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The Rationale of Medical Necessity

History

Documentation (S + O)

- Functional improvement reported by the patient?
- *Objective* measures that show improvement

Diagnosis

Rationale (MDM)

Treatment Plan

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The Rationale of Medical Necessity

History
Documentation (S + O)
Diagnosis
Rationale (MDM)
Treatment Plan

- Diagnose specifically
- Complicating factors?
- Hierarchy of codes

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The Rationale of Medical Necessity

History
Documentation (S + O)
Diagnosis
Rationale (MDM)
Treatment Plan

- Number and complexity of problems addressed
- Amount of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality

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The Rationale of Medical Necessity

History
Documentation (S + O)
Diagnosis
Rationale (MDM)
Treatment Plan

- Frequency and duration of care
- Treatment Goals include objective measures to evaluate treatment effectiveness
- Care plan
- Rationale of services

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NEW!

REQUIRED CORPORATE COMPLIANCE AND HIPAA MANUAL BUNDLE USE PROMO CODE BUNDLEIT FOR DISCOUNT PRICE ON CHECKOUT

www.Askmario.com

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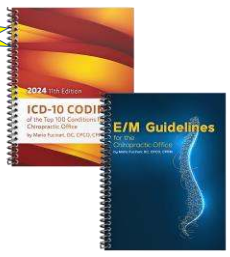
NEW!



E/M GUIDELINES AND ICD-10 2024 EDITION MANUAL BUNDLE USE PROMO CODE BUNDLEIT FOR DISCOUNT PRICE ON CHECKOUT

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If you have questions…

- www.FootLevelers.com
- www.Askmario.com
- ICD10 Coding Book and Manuals at www.Askmario.com
- E-mail: Doc@AskMario.com

AskMario

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