Delivering Best Practices in Patient-Centered Care:

Record Keeping

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Takeaways

- Know what third parties want to see in your records
- Know what things could trigger audits in your records
- Document initial visits / assessments perfectly
- Document subsequent / treatment visits perfectly

Documentation

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

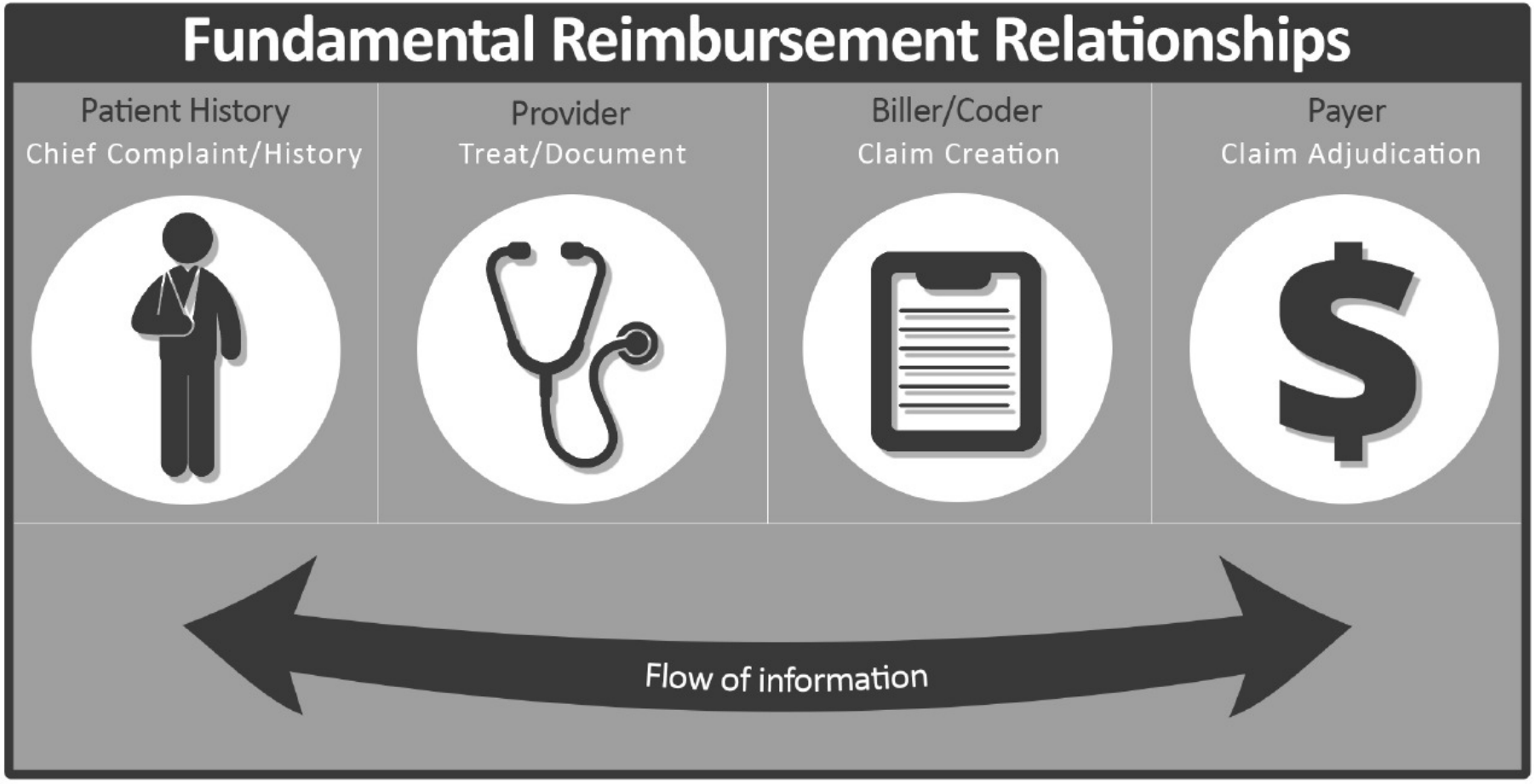
Is your documentation a weakness to be exploited by those who do not want to pay?

Or, is it a shield that protects you from liability and audits?

Denials

- Payers often believe that services rendered were unnecessary because:
  - There were too many visits
  - There were too many (or the wrong) services at each visit
  - Billing does not match documentation
- Good documentation can prove that:
  - The visits were medically necessary
  - The services were needed to help the patient get better
  - The billing is an accurate reflection of the record

Figure 4.1


Fundamental Reimbursement Relationships
Patient History
Chief Complaint/History
Provider
Treat/Document
Biller/Coder
Claim Creation
Payer
Claim Adjudication
Flow of information

VF4

Medical Necessity

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

Quick Check

1. Does the patient have a **complaint** in the area treated?
2. Are there objective findings to **explain the cause** of the complaint?
3. Does the record show a clear **plan** to correct the problem?
4. Does the record show **progress** towards measurable goals?

VF4 Slide 7: 5. Do you monitor and document changes and assess progress in the goals on every subsequent visit

Vivi-Ann Fischer, 3/13/2016

VF5

The Medical Necessity Recipe

1. Complaint
2. Explanation
3. Plan
4. Progress

*mechanism of trauma

VF5 Slide 8: 3. Plan with measurable goals

Vivi-Ann Fischer, 3/13/2016

Chiropractic Services Targeted

- 2014 CERT Improper Payment Report
  - 54.1% of chiropractic claims were paid improperly
    - 92.2% of those improper payments were due to insufficient documentation
- 2013 Palmetto GBA: Payment error rate 84.4%

Figure 4.2

Documentation Errors by Doctors of Chiropractic	
Element	**Percentage of Documentation Errors by Doctors of Chiropractic**
Evaluation: Improper or missing	34%
Diagnosis: Improper or missing	33%
Treatment plan: Insufficient	83%
Medical necessity not shown or miscoded	67%
Contraindications not checked	66%

VF3

Auditors favorite targets

- Illegible records
- Missing dates
- Missing signature
- Missing informed consent
- Missing re-assessment
- Missing patient identifiers
- Missing metrics/objective
- Blanks used to indicate "WN
- Missing legend for abbreviations
- Missing care plan
- Cloned records
- Billing only 98940
- Using travel cards

Slide 10

VF3 Slide 11: add billing all 98940, billing all 98941, billing only cash, travel cards "Acute care is ot the presence of sublusations and pain!

Vivi-Ann Fischer, 3/13/2016

Cloned records

Patient Visit	Subjective Documentation
Day One	"The patient is troubled by a moderate grade of intermittent dull pain with stiffness and soreness in her head on both sides."
Day Two	"In both sides of her head she is afflicted by a moderate grade of dull pain with stiffness and soreness which occurs intermittently."
Day Three	"The patient is afflicted by an intermittent dull pain with stiffness and soreness of a moderate degree in her head bilaterally."

Patient Visit	Objective Documentation
Day One	"Evidence of subluxation is detected coupled with tender deep paraspinal musculatures located at the middle and lower cervical regions on both sides."
Day Two	"Joint dysfunction is noted coupled with tenderness located in the middle and lower cervical areas on both sides."
Day Three	"The presence of subluxation is apparent, plus tender deep paraspinal musculatures overlying the lower and middle cervical region on both sides."

Bad Records

Bad records are:

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

Problem Oriented Medical Record

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

Problem Oriented Medical Record

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

SOAP

- Subjective
- Objective
- Assessment
- Plan

- Only 1/6 of a Problem Oriented Medical Record (POMR)

SOAP

Subjective

- Response to last treatment?
- Changes in symptoms?
- Pain scale changes?
- ADL performance?

Objective

- Physical exam findings
  - Neuro/ortho tests +/-
  - Inspection, palpation
- Outcomes Assessment retest

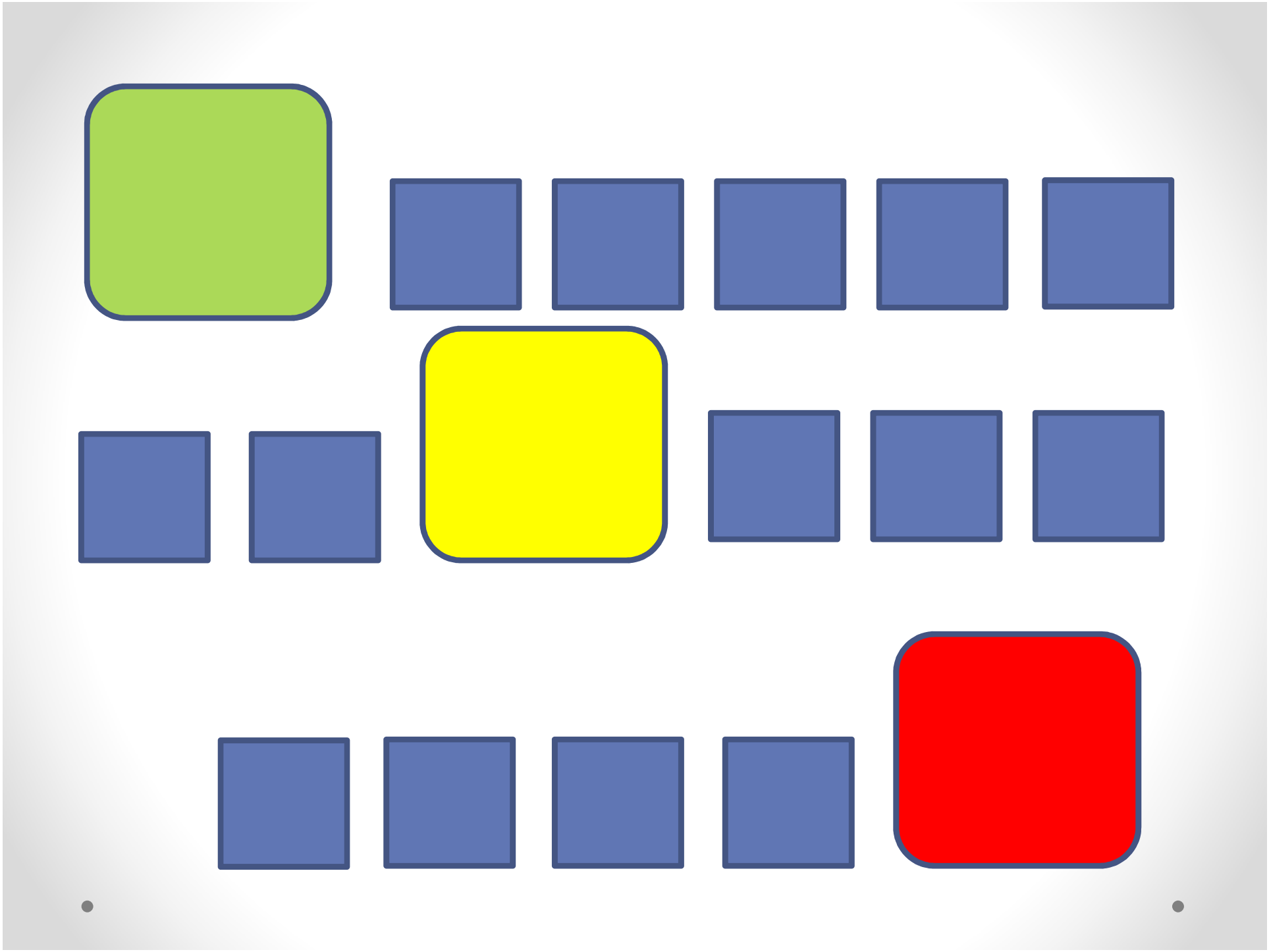
SOAP

Assessment

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

Plan

- Procedures performed
- Home instructions
- Changes to plan
- Next visit date



Assessments and Treatments

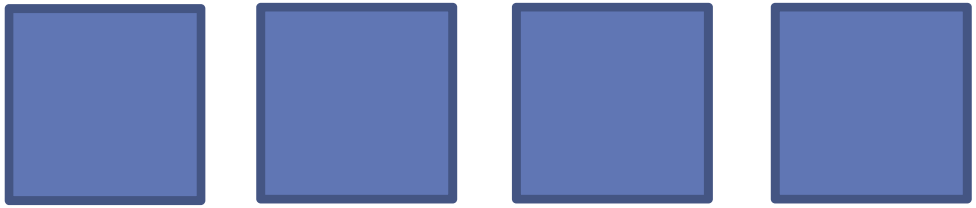
Assessment visit (similar to a typical visit to a medical doctor):

- Note subjective findings
- Record objective test results and observations
- Assess patient's condition/diagnosis
- Formulate plan with objective goals

Assessments and Treatments

Treatment visit (put the plan into action, like an MD trying out an Rx)

- Note subjective changes
- Record objective changes
- Assess whether or not patient is "on course"
- Don't update the plan until the next "Assessment visit"



A reviewer would need a "block" of records between the "Assessment visits". "Treatment visits" may not include sufficient info.

Medicare Outline

- Participation
- Indications
- Limitations
- Terminology
- Documentation
  - Subluxation
  - Initial Visit
  - Subsequent Visit
- Claims
- ABNs

Sources

- Title XVIII of the Social Security Act, Section 1833(e) and Section 1862(a)(1)(A)
- Code of Federal Regulations, 42 CFR 410
- *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 5, Section 70.6
- *Medicare Benefit Policy Manual*, Chapter 15, Section 30.5 and Section 240
- *Local Coverage Determination L33613, Chiropractic Services,* National Government Services

Medicare

- CMS is "Centers for Medicare & Medicaid Services"
- Prior to 2001, it was HCFA, the "Healthcare Finance Administration"
- More than 55 million beneficiaries, mostly over 65 years old.
- Medicare sets the standard for the health insurance industry
- Even if you refuse to deal with them, you need to know what they're thinking!

Participation

Participation

PAR or not to PAR

PAR agrees to 4 things:

- Accept assignment
- Accept Medicare charge as payment in full
- Collect deductible and coinsurance
- Renew PAR status automatically annually

Chiropractors may not “opt out”

Participation

PAR get the following “perks”

- 5% higher reimbursement than non-PAR
- Payment within 2 weeks
- Medicare Remittance Notice with each claim
- Provider Directory listing
- Claims forwarded to a qualified Medigap

nonPAR gets none of this

- But you can charge 15% more than the "allowed amount"-called the "limiting charge"

Participation

Extra tips:

- All new enrollees and those changing anything (phone number, etc) must accept payment by EFT (must recertify every 5 years)
- Note that, as part of the agreement, Medicare is allowed to pull money out of the account in the event of overpayment
- Mitigate your risk by creating a separate account just for Medicare and pull the money out, leaving a minimum balance of $50-$100

Indications

Medical necessity

- Medicare definition of medical necessity under Title XVIII of the Social Security Act, section 1862 (a)(1)(A):

  No payment may be made under Part A or Part B for any expenses incurred for items or services, which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Active Treatment

- Patient must have a significant health problem in form of a neuromusculoskeletal condition necessitating treatment.
- The manipulative services rendered must have a direct therapeutic relationship to the patient's condition.
- Patient must have reasonable expectation of recovery or improvement of function.

Acute Subluxation

- Patient is being treated for a new injury, identified by x-ray or physical exam (PART).
- Result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.

Chronic Subluxation

- Condition is not expected to significantly improve or be resolved with further treatment, but where continued therapy can be expected to result in some functional improvement.
- When clinical status has remained stable (no more objective clinical improvements), it is considered maintenance therapy.

Acute Exacerbation

- Temporary, but marked deterioration of the patient's condition that is causing significant interference with activities of daily living.
- To support medical necessity, record must specify:
  - Date of occurrence
  - Nature of the onset
- Treatment should result in improvement or arrest deterioration within a reasonable period of time.

Medical Necessity

Some payers specifically state:

"Strains, sprains, nerve pain and functional mechanical disabilities of the spine are considered to be reasonable and necessary therapeutic grounds for chiropractic manipulative treatment."

Maintenance

- Services that seek to
  - Prevent disease
  - Promote health
  - Prolong or enhance quality of life
  - Maintain or prevent deterioration of a chronic condition
- Further clinical improvement cannot reasonably be expected from continuous ongoing care.
- Treatment is supportive rather than corrective in nature.

Maintenance

- Mandatory claim submission
  - Requires providers to bill CMS, even if service might deny (98940-98942)
- Do not append AT modifier
- Consider using Z41.9
- Obtain ABN and use GA modifier

Contraindications

- Relative
  - Hypermobility
  - Severe demineralization
  - Benign bone tumors of spine
  - Bleeding disorders
  - Progressive radiculopathy
- Absolute
  - Acute arthropathies
  - Acute fractures
  - Malignancies of spine
  - Infections of spine
  - Myelopathy
  - Vertebrobasilar insufficiency syndrome
  - Major artery aneurysm

Limitations

Coverage

Only covered service is treatment of the spine, limited specifically to manual manipulation to correct a subluxation

- Hand held devices allowed
  - But must be controlled manually
  - CMS does not allow additional payment for the device

No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered.

- Some payers state specifically that thermography, pro-adjustor, and neurocalcometer not covered

Excluded services

- Excluded services are the beneficiary's responsibility.
- May bill patient without billing Medicare for
  - Acupuncture
  - Counseling/education
  - Dietary advice or nutritional supplements
  - Lab or other diagnostic tests
  - Modalities or therapeutic procedures (exercise, ultrasound)
  - Office visits
  - Supplies (pillows or vitamins)
  - Supportive devices (braces, orthotics)
  - X-rays

Other limitations

- The mere statement or diagnosis of "pain" is not sufficient to support medical necessity for treatment.
- Precise level of the subluxation must be specified to substantiate a claim for manipulation of each spinal region.
- The need for an extensive, prolonged course of treatment should be appropriate to the reported procedure code and documented clearly in the medical record.

Related Symptoms

- "These symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo),bone (osseo or osteo), rib (costo or costal) and joint (arthro)and be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, etc. "
- "Vertebral pinching of spinal nerves may cause headaches, arm, shoulder, and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such."

Frequency

Chiropractic manipulation service only reimbursed once per day

The frequency and duration of chiropractic treatment:

- Must be medically necessary
- Based on the individual patient's condition and response to treatment

Medical necessity determines visits, i.e. there is no set visit limit

Corrective treatment

- Goal driven
- Individualized treatment plan
- Short term
- Measurable progress towards goals
- “Pain” and “subluxation” alone is insufficient
- Use AT modifier with CPT codes 98940-98942

Medical Necessity

- Coverage will be denied if there is not a reasonable expectation that the continuation of treatment would result in improvement of the patient's condition.

- Continued repetitive treatment without a clearly defined clinical end point is considered maintenance therapy and is not covered.

Terminology

Medicare Terminology

- **Subluxation**- a motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact.
- Some common examples of acceptable descriptive terms for the nature of the abnormalities:
  - Off-centered, misalignment, malpositioning
  - Spacing: abnormal, altered, decreased, increased
  - Incomplete dislocation, rotation
  - Listhesis: antero, postero, retro, lateral, spondylo
  - Motion: limited, lost, restricted, flexion, extension, hypermobility, hypomobility, aberrant

Medicare Terminology

- **Chiropractic Manipulative Treatment-** manual treatment to influence joint and neurophysiological function
- The following terms can be used to describe the manual manipulation:
  - Spine or spinal adjustment by manual means
  - Spine or spinal manipulation
  - Manual adjustment
  - Vertebral manipulation or adjustment

Medicare Terminology

- **Dynamic thrust-** therapeutic force or maneuver delivered by the physician during manipulation in the anatomic region of involvement.

Medicare Terminology

- **Limiting charge-** the maximum amount that most non-participating providers are allowed to charge for services to a Medicare beneficiary on an unassigned basis.
- **Allowed amount-** maximum amount providers who accept assignment can charge for covered services

Medicare Terminology

- The word "correction" may be used in lieu of "treatment"

- Extraspinal (not covered) includes
  - Head
  - Lower extremities
  - Upper extremities
  - Rib cage
  - Abdomen

Documentation
Subluxation

Documentation

Subluxation

Medical record must contain documentation that fully supports the medical necessity for services.

Level of subluxation must bear a direct relationship to the patient's symptoms, and the symptoms must be directly related to the level of the subluxation that has been diagnosed.

Documentation

Subluxation

Medical necessity requirements apply:

- whether subluxation is demonstrated by x-ray or physical exam
- Applies to both initial and subsequent visits
- Both participating and non-participating providers

Document precise level of subluxation:

a) List exact bones involved
   - C2, L4, etc.

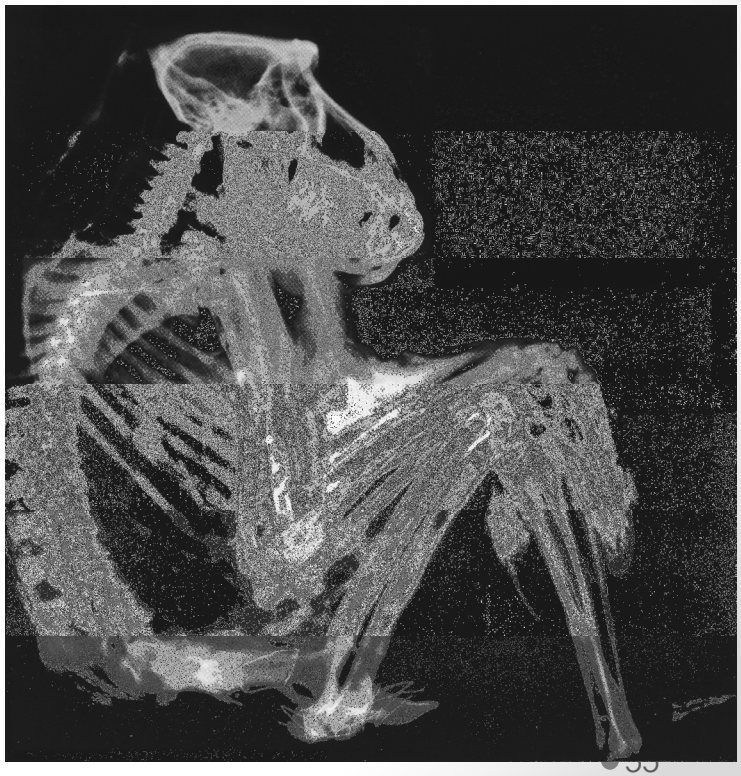
b) Area/region, if it implies certain bones
   - Lumbo-sacral
   - Sacro-iliac

Documentation

Subluxation

1. **X-ray**

- taken no more than 12 months prior to initiation of treatment
- Taken 3 months following the initiation of treatment
- Previous CT or MRI okay
- Enter x-ray date Item 19
  - e.g. 2/21/15 “x-ray date”



Documentation

Subluxation

2. **Physical Examination -** Evaluation of musculoskeletal/nervous system to identify:

P.A.R.T.

Documentation

Subluxation

P **Pain/tenderness**

Documentation

Subluxation

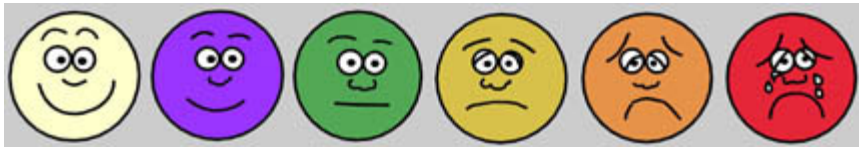
Pain/tenderness evaluated in terms of *location, quality, and intensity*

Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation.

Documentation

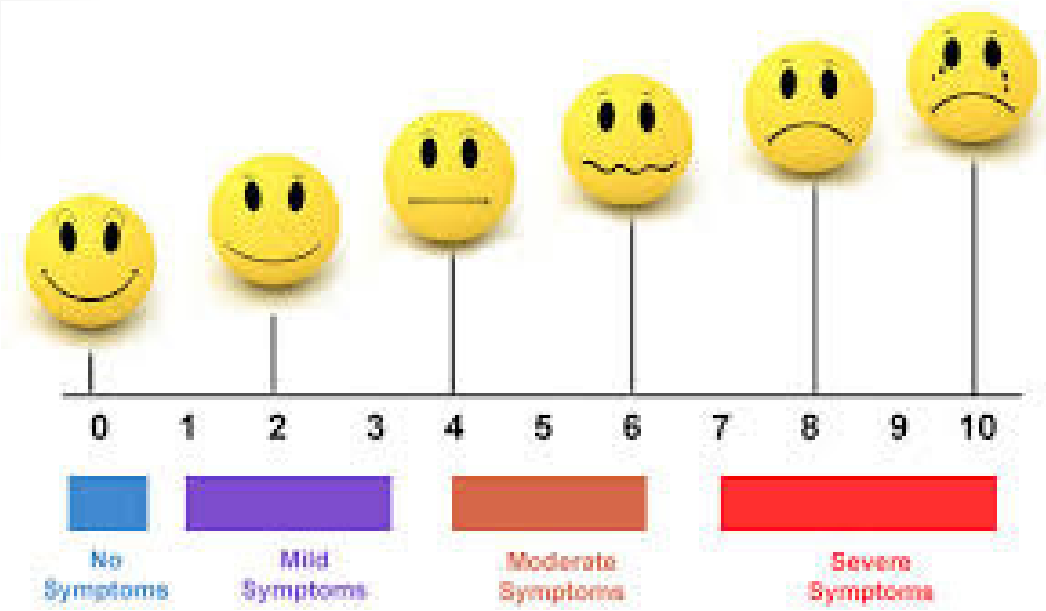
Subluxation

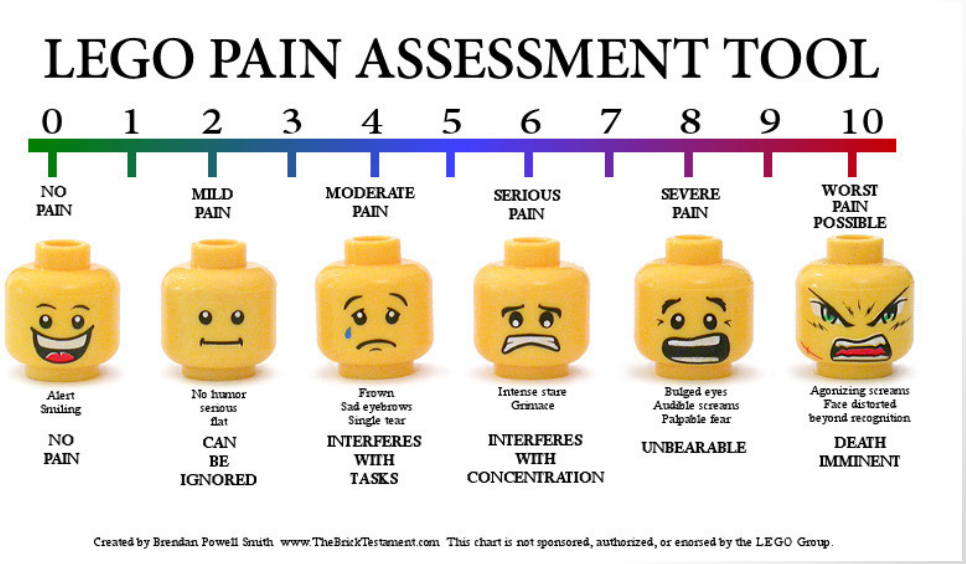
Examples of standardized pain assessment tools include, but are not limited to:



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

- Important: The name of the standardized tool used to assess the patient's pain must be documented in the medical record


0 1 2 3 4 5 6 7 8 9 10
No Symptoms
Mild Symptoms
Moderate Symptoms
Severe Symptoms


LEGO PAIN ASSESSMENT TOOL
0 1 2 3 4 5 6 7 8 9 10
NO PAIN
MILD PAIN
MODERATE PAIN
SERIOUS PAIN
SEVERE PAIN
WORST PAIN POSSIBLE
Alert
Smiling
NO PAIN
No humor
serious
flat
CAN BE IGNORED
Frown
Sad eyebrows
Single tear
INTERFERES WITH TASKS
Intense stare
Grimace
INTERFERES WITH CONCENTRATION
Bulged eyes
Audible screams
Palpable fear
UNBEARABLE
Agonizing screams
Face distorted
beyond recognition
DEATH IMMINENT
Created by Brendan Powell Smith www.TheBrickTestament.com This chart is not sponsored, authorized, or enorsed by the LEGO Group.

Documentation

Subluxation

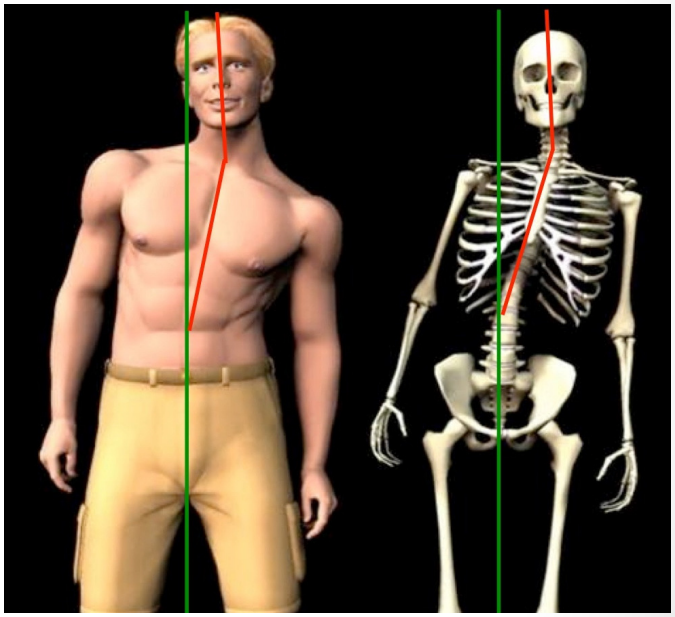
A Asymmetry

Documentation

Subluxation

- Asymmetry/misalignment identified on a sectional or segmental level

- Asymmetry/misalignment may be identified on a sectional or segmental level through one or more of the following:
  - Observation (posture and gait analysis),
  - Static palpation for misalignment of vertebral segments,
  - Diagnostic imaging



Documentation

Subluxation

R Range of Motion

Documentation

Subluxation

Range of motion abnormalities may be identified through one or more of the following:

- Motion palpation
- Observation
- Diagnostic imaging
- Range of motion measurements (Inclinometers)

Documentation

Subluxation

T

Tissue

Documentation

Subluxation

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

- Tissue/Tone texture may be identified through one or more of the following procedures:
  - Observation
  - Palpation
  - Use of instruments

Documentation

Subluxation

To demonstrate a subluxation based on examination **<u>two of the four criteria</u>** must be:

<u>Asymmetry</u>
<u>Or</u>
<u>Range Of Motion</u>

P.A.R.T.

Documentation
Initial Visit

Documentation

Initial Visit

1. History
2. Description of Present Illness
3. Physical Exam
4. Diagnosis
5. Treatment Plan
6. Date of Initial Treatment

Documentation

Initial Visit: History

- Symptoms causing patient to seek treatment *[Chief Complaint]*
- Family history if relevant *[Family History]*
- Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history) *[Past History]*
- Plus…

Documentation

Initial Visit

1. History
2. Description of Present Illness
3. Physical Exam
4. Diagnosis
5. Treatment Plan
6. Date of Initial Treatment

Documentation

Initial Visit: Description of Present Illness

- Mechanism of trauma *[History of Present Illness]*
- Quality and character of symptoms/problem *[HPI]*
- Onset, duration, intensity, frequency, location, and radiation of symptoms *[HPI]*
- Aggravating or relieving factors *[HPI]*
- Prior interventions, treatments, medications, secondary complaints *[Past History]*
- Symptoms causing patient to seek treatment *[Chief Complaint]*

Documentation

Initial Visit

1. History
2. Description of Present Illness
3. Physical Exam
4. Diagnosis
5. Treatment Plan
6. Date of Initial Treatment

Documentation

Initial Visit: Physical Exam

- Objective measures should be used at the beginning, during, and after treatment is recommended to quantify progress.
- *Musculoskeletal System 1997 Documentation Guidelines* for Evaluation and Management codes provides a great outline for a full evaluation of the musculoskeletal/nervous system.
- Clearly outline PART for each subluxation treated (do this for all patients, all payers)

Documentation

Initial Visit

1. History
2. Description of Present Illness
3. Physical Exam
4. Diagnosis
5. Treatment Plan
6. Date of Initial Treatment

Documentation

Initial Visit: Diagnosis

Primary diagnosis must be

- M99.01 *Segmental and somatic dysfunction of cervical region*
- M99.02 *Segmental and somatic dysfunction of thoracic region*
- M99.03 *Segmental and somatic dysfunction of lumbar region*
- M99.04 *Segmental and somatic dysfunction of sacral region*
- M99.05 *Segmental and somatic dysfunction of pelvic region*

Secondary diagnosis must be a neuromusculoskeletal condition based on the presenting problem.

- List primary/secondary for each region treated/billed

Documentation

Initial Visit: Diagnosis

- Neurological diagnoses like sciatica (M54.3-) will carry more weight than DDD or other structural diagnoses
- Soft tissue such as spasm (M62.830) or myalgia (M79.1) are the least significant
- Documented persistent symptoms, recurrent episodes, severe pain, anomalies, or pathologies can justify double the recovery time

Diagnosis Hierarchy

Short term

- G43 *Migraines*
- G44 *Headaches*
- M24.5 *Contracture*
- M47 *Spondylosis*
- M48 *DISH*
- M54 *Dorsalgia*
- R51 *Headache*

Moderate term

- G54 *Nerve root and plexus disorders*
- G57 *Nerve lesions*
- M12-M16 *Arthritis*
- M25 *Joint disorders*
- M43, Q76.2 *Spondylolisthesis*
- M46 *Spinal enthesiopathy*
- M48 *Spinal Stenosis*
- M50, M51 *Disc disorders*
- M53 *Other dorsopathies, NEC*
- M54 *Radiculopathies*
- M60 *Myositis*
- M62 *Spasm*
- M79 *Myalgia*
- M99 *Stenosis*
- S13, S23, S33 *Sprain*
- S16 *Strain*

Long term

- M48 *Traumatic spondylopathies*
- M50 *DDD*
- M51 *Disc displacement*
- M54 *Sciatica*
- M96 *Postlaminectomy*
- M99 *Stenosis*

Note: These are only categories. Use the Tabular List for more details.

Diagnosis Hierarchy

1. Nerve related disorders (e.g. radiculopathy)
2. Acute injuries (e.g. sprains and strains)
3. Structural diagnoses (e.g. degenerative disc disease)
4. Functional diagnoses (e.g. difficulty with walking)
5. Soft tissue problems (e.g. myalgia)
6. Symptoms (e.g. neck pain)
7. Complicating factors/comorbidities (e.g. diabetes)
8. External causes (e.g. place and activity)

Documentation

Initial Visit: Diagnosis

- When coding for symptoms, add the phrase "due to" for better specificity.
- Complicating factors should also be diagnosed, if relevant.
- Create "Provider Documentation Guides" for your most commonly used diagnoses.

Provider Documentation Guides

1. The condition
2. The forward and backward General Equivalence Mappings (GEMs)
3. Helpful information
4. The applicable guidelines at each level:
    - Chapter
    - Block
    - Category
    - Subcategory
    - Code
5. The information conveyed by the 3rd character
6. The information conveyed by the 4th character, if applicable
7. The information conveyed by the 5th character, if applicable
8. The information conveyed by the 6th, and if applicable, 7th character

Disc Degeneration, Lumbosacral Region

ICD-9-CM: 722.52 Degeneration of lumbar or lumbosacral intervertebral disc

Mapping

Forward:

M51.36 Other intervertebral disc degeneration, lumbar region

M51.37 Other intervertebral disc degeneration, lumbosacral region

Backward:

M51.36 Other intervertebral disc degeneration, lumbar region

M51.37 Other intervertebral disc degeneration, lumbosacral region

What to Document

3rd Character: Type of dorsopathy
4th Character: Type of disorder
5th Character: Location

Document:
External cause, if known.

The exact spinal regions affected. ICD-1Ø-CM has expanded spinal regions and some are linked to specific levels, so be sure to document the exact region and levels affected.

Dorsopathy:
spinal disease

OTHER DORSOPATHIES (M5Ø-M54)

Excludes1:
current injury - see injury of spine by body region
discitis NOS (M46.4-)

3rd Character

Document: Type of dorsopathy

M5Ø- Cervical disc disorders

M51- Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders

M53- Other and unspecified dorsopathies, not elsewhere classified

M54- Dorsalgia

4th Character

Document: Type of disorder

Excludes2:
cervical and cervicothoracic disc disorders (M5Ø.-)
sacral and sacrococcygeal disorders (M53.3)

M51.Ø- Thoracic, thoracolumbar and lumbosacral intervertebral disc disorders with myelopathy

M51.1- Thoracic, thoracolumbar and lumbosacral intervertebral disc disorders with radiculopathy

M51.2- Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement

Chapter Guidelines

13. Diseases of the musculoskeletal system and connective tissue (MØØ-M99)

Notes:

Use an external cause code following the code for the musculoskeletal condition, if applicable, to identify the cause of the musculoskeletal condition

Excludes2:

arthropathic psoriasis (L4Ø.5-)
certain conditions originating in the perinatal period (PØ4-P96)
certain infectious and parasitic diseases (AØØ-B99)
compartment syndrome (traumatic) (T79.A-)
complications of pregnancy, childbirth and the puerperium (OØØ-O9A)
congenital malformations, deformations, and chromosomal abnormalities (QØØ-Q99)
endocrine, nutritional and metabolic diseases (EØØ-E88)
injury, poisoning and certain other consequences of external causes (SØØ-T88)
neoplasms (CØØ-D49)
symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (RØØ-R94)

DORSOPATHIES (M4Ø-M54)

M51.3- Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
M51.4- Schmorl's nodes
M51.8- Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders
M51.9 Unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder

5th Character

Document: Location

M51.34 Other intervertebral disc degeneration, thoracic region
M51.35 Other intervertebral disc degeneration, thoracolumbar region
M51.36 Other intervertebral disc degeneration, lumbar region
M51.37 Other intervertebral disc degeneration, lumbosacral region

6th Character

N/A

7th Character

N/A

Sample from "Provider Documentation Guides" page 478 of *2016 ICD-10-CM Coding for Chiropractic*

Disc Degeneration, Lumbosacral Region

ICD-9-CM: 722.52 Degeneration of lumbar or lumbosacral intervertebral disc

Mapping

Forward:

M51.36 Other intervertebral disc degeneration, lumbar region

M51.37 Other intervertebral disc degeneration, lumbosacral region

Backward:

M51.36 Other intervertebral disc degeneration, lumbar region

M51.37 Other intervertebral disc degeneration, lumbosacral region

What to Document

3rd Character: Type of dorsopathy
4th Character: Type of disorder
5th Character: Location

Document:
External cause, if known.

The exact spinal regions affected. ICD-1Ø-CM has expanded spinal regions and some are linked to specific levels, so be sure to document the exact region and levels affected.

Dorsopathy:
spinal disease

OTHER DORSOPATHIES (M5Ø-M54)

Excludes1:
current injury - see injury of spine by body region
discitis NOS (M46.4-)

3rd Character

Document: Type of dorsopathy

M50- Cervical disc disorders

M51- Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders

M53- Other and unspecified dorsopathies, not elsewhere classified

M54- Dorsalgia

4th Character

Document: Type of disorder

Excludes2:
cervical and cervicothoracic disc disorders (M5Ø.-)
sacral and sacrococcygeal disorders (M53.3)

M51.Ø- Thoracic, thoracolumbar and lumbosacral intervertebral disc disorders with myelopathy

M51.1- Thoracic, thoracolumbar and lumbosacral intervertebral disc disorders with radiculopathy

M51.2- Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement

Chapter Guidelines

13. Diseases of the musculoskeletal system and connective tissue (MØØ-M99)

Notes:

Use an external cause code following the code for the musculoskeletal condition, if applicable, to identify the cause of the musculoskeletal condition

Excludes2:

arthropathic psoriasis (L40.5-)

certain conditions originating in the perinatal period (PØ4-P96)

certain infectious and parasitic diseases (AØØ-B99)

compartment syndrome (traumatic) (T79.A-)

complications of pregnancy, childbirth and the puerperium (OØØ-O9A)

congenital malformations, deformations, and chromosomal abnormalities (QØØ-Q99)

endocrine, nutritional and metabolic diseases (EØØ-E88)

injury, poisoning and certain other consequences of external causes (SØØ-T88)

neoplasms (CØØ-D49)

symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (RØØ-R94)

DORSOPATHIES (M4Ø-M54)

M51.3- Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration

M51 Schmorl's nodes

M51. Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders

M51. Unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder

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Document: Location

M51.34 Other intervertebral disc degeneration, thoracic region

M51.35 Other intervertebral disc degeneration, thoracolumbar region

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6th Character

N/A

7th Character

N/A

Sample from "Provider Documentation Guides" page 478 of *2016 ICD-10-CM Coding for Chiropractic*

Provider Documentation Guides

1. The condition
2. The forward and backward General Equivalence Mappings (GEMs)
3. Helpful information
4. The applicable guidelines at each level:
    - Chapter
    - Block
    - Category
    - Subcategory
    - Code
5. The information conveyed by the 3rd character
6. The information conveyed by the 4th character, if applicable
7. The information conveyed by the 5th character, if applicable
8. The information conveyed by the 6th, and if applicable, 7th character

Diagnosis Hierarchy

Spondylopathies [M45-M49]

M45.4	Ankylosing spondylitis of thoracic region	
M45.5	Ankylosing spondylitis of thoracolumbar region	
M46.44	Discitis, unspecified, thoracic region	[M]
M46.45	Discitis, unspecified, thoracolumbar region	[M]
M47.24	Other spondylosis with radiculopathy, thoracic region	[S]
M47.25	Other spondylosis with radiculopathy, thoracolumbar region	[S]
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region	[S]
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region	[S]
M48.04	Spinal stenosis, thoracic region	[L]
M48.05	Spinal stenosis, thoracolumbar region	[L]
M48.24	Kissing spine, thoracic region	
M48.25	Kissing spine, thoracolumbar region	

Sample from "Anatomic Diagnosis Code List" page 52 of *2016 ICD-10-CM Coding for Chiropractic*

Figure 2.10

Clinical Example

Relevant History: Patient presents with generalized neck pain after her pick-up truck was rear ended yesterday by a bus while waiting at a stop light. Patient reports pain and stiffness from C3 to C6 with extension and rotation. It improves throughout the day and with movement.

Relevant Exam Findings: Cervical paraspinal muscle pain is present during isometric muscle contraction, as well as during passive assisted motion. Cervical flexion/extension x-rays show increased anterior translation at C4, C5, and C6, but no other relevant findings. Tenderness and swelling is evident in the mid-cervical region. Chiropractic subluxation is found at C5, due to right spinous rotation palpated as well as visibility on AP x-ray. Trigger points are identified on the right from C4 to C6.

Codes that might be assigned to this case:

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Diagnostic Statement: Patient suffers from segmental dysfunction in the cervical region with myofascial pain syndrome in the right cervical musculature. In addition, there is evidence of strain of the muscles at the neck level, as well as sprain of the ligaments of the cervical spine. Patient was the driver of a pick-up truck that was in a collision with a bus in a traffic accident on a paved roadway. Patient is now in active treatment.

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Figure 2.11

Diagnostic Statement: Patient suffers from segmental dysfunction in the cervical region with myofascial pain syndrome in the right cervical musculature. In addition, there is evidence of strain of the muscles at the neck level, as well as sprain of the ligaments of the cervical spine. Patient was the driver of a pick-up truck that was in a collision with a bus in a traffic accident on a paved roadway. Patient is now in active treatment.

Figure 2.10

Clinical Example

Relevant History: Patient presents with generalized neck pain after her pick-up truck was rear ended yesterday by a bus while waiting at a stop light. Patient reports pain and stiffness from C3 to C6 with extension and rotation. It improves throughout the day and with movement.

Relevant Exam Findings: Cervical paraspinal muscle pain is present during isometric muscle contraction, as well as during passive assisted motion. Cervical flexion/extension x-rays show increased anterior translation at C4, C5, and C6, but no other relevant findings. Tenderness and swelling is evident in the mid-cervical region. Chiropractic subluxation is found at C5, due to right spinous rotation palpated as well as visibility on AP x-ray. Trigger points are identified on the right from C4 to C6.

Codes that might be assigned to this case:

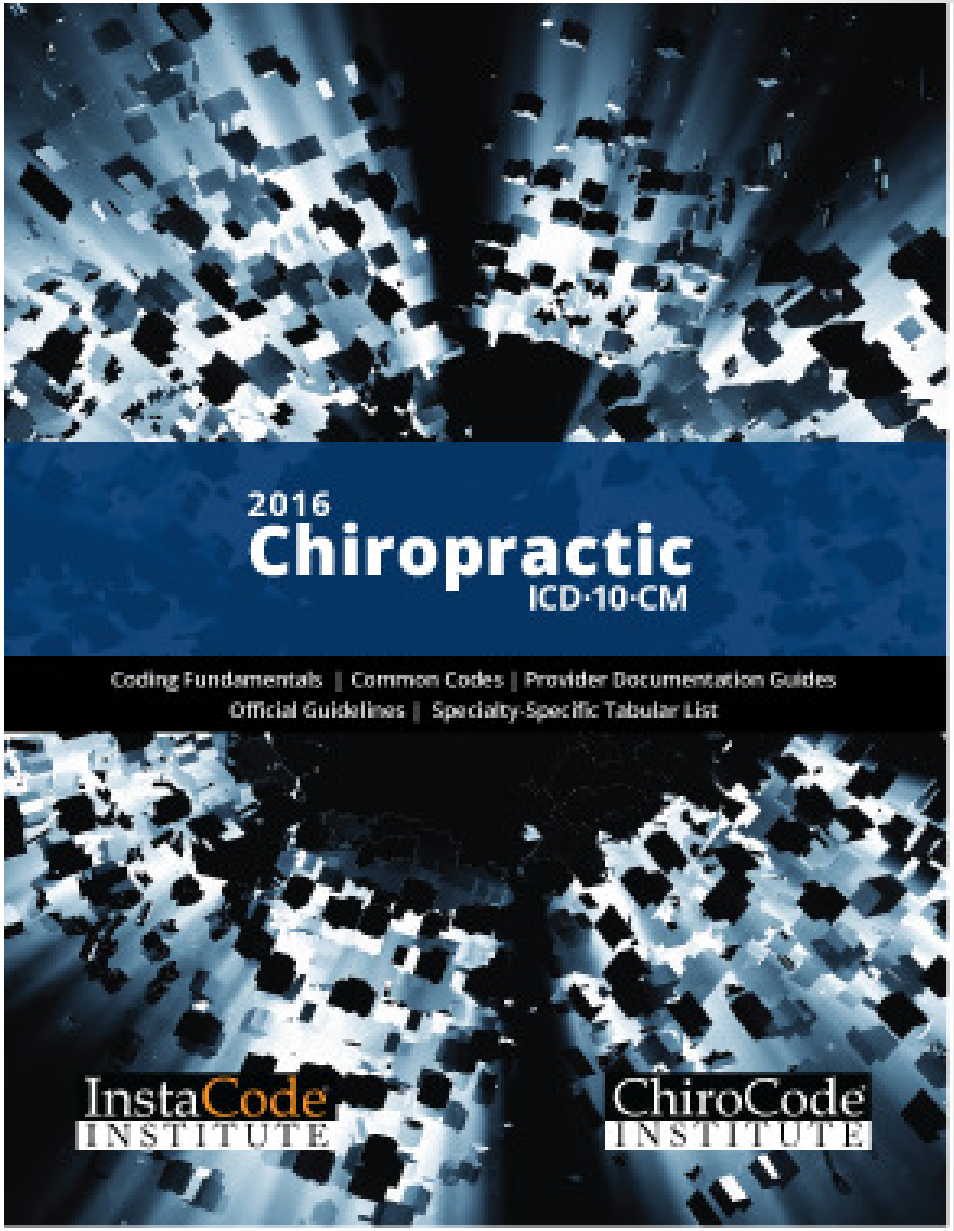
S13.4xxA *Sprain of ligaments of cervical spine, initial encounter*
S16.1xxA *Strain of muscle, fascia, and tendon at neck level, initial encounter*
M79.1 *Myalgia*
M99.Ø1 *Segmental and somatic dysfunction, cervical region*
V54.5xxA *Driver of pick-up truck or van in collision with heavy transport vehicle or bus in traffic accident, initial encounter*
Y92.41Ø *Street, highway and other paved roadway, unspecified*

Figure 2.11

Diagnostic Statement: Patient suffers from segmental dysfunction in the cervical region with myofascial pain syndrome in the right cervical musculature. In addition, there is evidence of strain of the muscles at the neck level, as well as sprain of the ligaments of the cervical spine. Patient was the driver of a pick-up truck that was in a collision with a bus in a traffic accident on a paved roadway. Patient is now in active treatment.

2016 ICD-10 Coding for Chiropractic is available at ChiroCode.com

This part of this presentation is covered in pages 37-47, Chapter 2



Documentation

Initial Visit

1. History
2. Description of Present Illness
3. Physical Exam
4. Diagnosis
5. Treatment Plan
6. Date of Initial Treatment

Documentation

Initial Visit: Treatment Plan

1. Recommended level of care (duration and frequency of visits)
   - Acute treatment is shorter duration, higher frequency
   - Chronic treatment is longer duration, but lower frequency
   - Initial exam is not expected to provide all the answers. A treatment trial should be instituted and assessed to determine if the plan should change.
2. Specific treatment **goals**
   - With documentation of progress or lack thereof at subsequent visits
3. Objective measures to evaluate treatment effectiveness
   - Qualitative and/or quantitative

Documentation

Initial Visit: Treatment Plan

Goals should be measurable, such as:

- VAS, ADLs, OATs, ROM

Goals should be specific, such as:

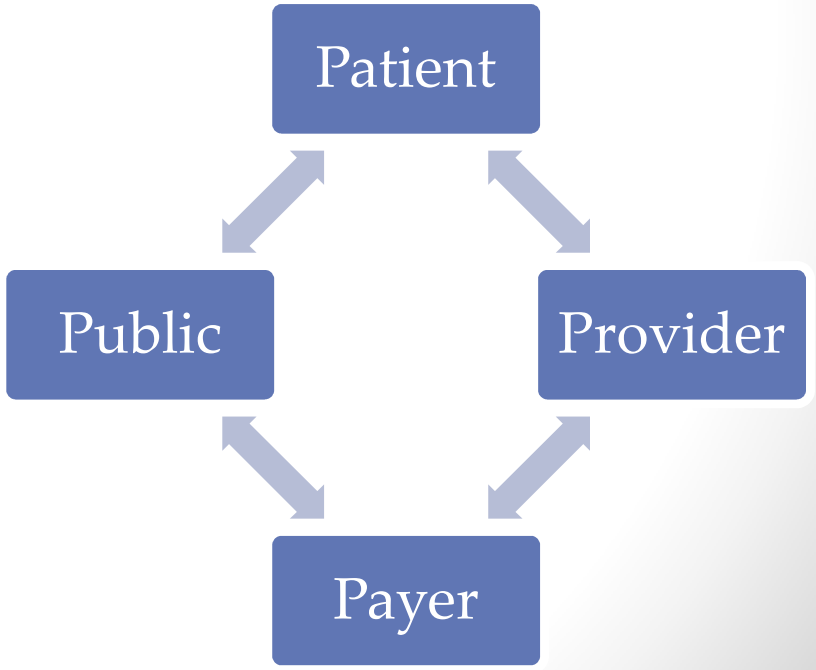
- Increased tolerance to standing without pain [ADL] for thirty minutes [duration of time] by 5/17/2016 [date].
- Improve OAT score 50% by 6/22/2016
- Unspecific goals would be "increase ROM and decrease pain"

Documentation

Initial Visit: Treatment Plan

Outcome Assessment Tools

"Outcomes in clinical practice provide the mechanism by which the health care provider, the patient, the public, and the payer are able to assess the end results of care and its effect upon the health of the patient and society."



Documentation

Initial Visit: Treatment Plan

Outcome Assessment Tools

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

- 30% improvement = meaningful change
- 50% improvement = substantial change

Documentation

Initial Visit: Treatment Plan

Outcome Assessment Tools

Neck Disability Index (NDI)

Modified Oswestry Low Back Disability Index

- Ten questions, six responses scored on an ascending scale (0, 1, 2, 3, 4, 5), total is divided by # of points possible
- Higher percentage = worse disability
- Administer at intake and every 6-12 visits, or 2-4 weeks
- Clinically meaningful change = 30-50%

Documentation

Initial Visit: Treatment Plan

Outcome Assessment Tools

THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

SECTION 1 - Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 6 - Standing

A I can stand as long as I want without pain.
B I have some pain on standing but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than 10 minutes without increasing pain.
F I avoid standing because it increases the pain immediately.

The questionnaire that the patient completes during the re-exam now looks like this:

THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

SECTION 1 - Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
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Documentation

Initial Visit: Treatment Plan

Prognosis is used to forecast the probable result of treatment for a patient's condition.

Short term – symptomatic

Long term – functional

1. Excellent	4. Poor
2. Good	5. Guarded
3. Fair	6. Unstable

Documentation

Initial Visit: Treatment Plan

Prognosis

1. **Excellent** – full symptomatic and functional recovery expected within 2-4 weeks
2. **Good** - Symptomatic and functional recovery is expected in approximately 4- 8 weeks but the patient may experience intermittent mild pain and some restriction of motion

Documentation

Initial Visit: Treatment Plan

Prognosis

3. **Fair** - The patient can expect to have a reduction of their symptom although some persistent pain and stiffness from the injury is expected and may require ongoing rehabilitation.
4. **Poor** - The nature of the patient's injury and preexisting conditions bring into doubt the likelihood of full recovery. It is expected that patient will continue to experience intermittent to occasional paresthesias along with occasional to frequent pain and stiffness, necessitating palliative care.

Documentation

Initial Visit: Treatment Plan

Prognosis

5. **Guarded** - The patient's condition is not expected to improve in the near future. They may expect to have continued muscle weakness and sensory deficit. Palliative and/or supportive care will be warranted for symptomatic relief and some improvement of function.
6. **Unstable** - Patient has not responded to the treatment trial and demonstrates evidence of deterioration. The likelihood of recovery with conservative care does not appear promising at this time. Surgical consult would be advisable.

Documentation

Initial Visit: Treatment Plan

- Plan of care should include recommendations for ongoing amelioration of musculoskeletal complaints, such as:
  - Home program, lifestyle modifications, etc
- Introduce as soon as possible, reinforce, and document in the medical record.

Documentation

Initial Visit

1. History
2. Description of Present Illness
3. Physical Exam
4. Diagnosis
5. Treatment Plan
6. Date of Initial Treatment

Documentation

Initial Visit: Date of Initial Treatment

	Reason For Encounter
History Past History	01/04/08- The patient enters the clinic with complaints of cervical pain and associated headaches. She states that she slipped and fell in her bathtub on week ago. She describes the neck pain as being more intense on the right side with some shooting pain in the right upper trapezius and right upper thoracic region. Over the counter meds offer only slight, temporary relief. Sleeping has been interrupted due to the neck pain. Patient relates past history of intermittent mild neck pain with no prior intervention necessary.
Exam	Examination today reveals +2/4 hypertonicity to the right cervical, right upper trapezius, right anterior scalene and right para thoracic musculature. Cervical foraminal compression test is positive for localized pain at the right lower cervical region with radiating pain into the right upper para thoracic and right upper trapezius region. Cervical flexion produces localized C6-C7 pain. Cervical range of motion: right rotation (RROT): 30 degrees, left rotation (LROT): 55 degrees; left lateral flexion (LLF): 10 degrees; right lateral flexion (RLF): 20 degrees; flexion (FLEX) 40 degrees; extension (EXT) 20 degrees
Assessment	Assessment today is one of an acute clinical state that coincides with the history or onset. Her diagnosis is 739.1, 784.0, 739.2 and 729.4.
Treatment Plan of Care	Manipulation today was performed on C2, C3, C6, C7, T4, T5 and T6. Patient will be seen on Thursday for follow up and anticipate twice next week with reevaluation for further scheduling.

Documentation

Initial Visit

1. History
2. Description of Present Illness
3. Physical Exam
4. Diagnosis
5. Treatment Plan
6. Date of Initial Treatment

Documentation
Subsequent Visit

Documentation

Subsequent Visit

1. History *[S]*
2. Physical exam *[O]*
3. Treatment given *[P]*
4. Progress *[A]*

Documentation

Subsequent Visit: History

- Review of chief complaint
- Changes since last visit
  - Following last treatment
  - Immediately preceding current visit
- System review if relevant

Documentation

Subsequent Visit: Physical Exam

- Exam of area of spine involved in diagnosis
- Assessment of change in patient condition since last visit (i.e. updates to objective measures)
- Evaluation of treatment effectiveness (i.e. progress towards goals from care plan)
- Documentation of the presence or absence of a subluxation must be present at every visit. (Use P.A.R.T.)
- If a significant and separately identifiable exam is performed, bill an E/M code with 25 modifier

Documentation

Subsequent Visit: Treatment Given

- Identify the precise level of subluxation treated and technique used.
- Include spinal segments that were adjusted but do not meet the criteria for medical necessity (compensatory segments), even though they are not covered.
- Include modalities and therapies, even though they are not covered services.
  - "… as outlined in treatment plan dated 6/12/2016" rather than repeating all details
- State "This is treatment 4 of 12" to let reviewers know that there is a plan.

Documentation

Subsequent Visit

1. History *[S]*
2. Physical exam *[O]*
3. Treatment given *[P]*
4. Progress *[A]*

Documentation

Subsequent Visit: Progress

- Document progress towards goals, or lack thereof, related to plan of care.
- For patients who have not achieved goals, document the clinical factors that contributed to the inability to meet the goals stated in the care plan.

Documentation

Subsequent Visit: Progress

- Changes in patient exam, status, progression and care plan should be maintained in records at each visit.
- Evaluation is ongoing, signs and symptoms must be rechecked during the course of treatment.
- Modify treatment as necessary

Documentation
Subsequent Visit

- List diagnosis codes at each visit
  - The word "same" is inadequate
  - If diagnosis changes from prior visit, explain how it relates to past history
  - If diagnosis is new, add new Initial Treatment Date to Item 14 on CMS-1500
- Re-evaluate each 30 days at a minimum
- Discharge when no further progress

	Reason For Encounter
History Past History	02/01/08- This patient enters the clinic today with complaints of continued lower back pain and radiating pain to the posterior and lateral aspect of the right upper leg. The pain continues to be more intense with prolonged sitting or standing in one position for any length of time. Lying down relieves the leg pain; however, the back pain persists. This patient states that he has received temporary relief with application of cold packs to the low back. Walking for any distance is difficult and increases the severity of the pain. The patient states he is able to sleep better since the last treatment and has avoided any lifting activities.
Exam	The patient presents to the clinic in a 15 degree left lateral and anterior flexed antalgic posture. Palpation reveals +3/4 hypertonicity to the para lumbar musculature. Minor sign is positive. Straight leg raiser test is positive to sharp stabbing pain at the left L4-5 level with radiating pain into the right posterior upper leg. Kemps test is positive to sharp right lower lumbar pain.
Assessment	There is a reduction in both the intensity of the pain and the para vertebral spasm since last visit. The patient is able to sit and stand for longer periods of time without the debilitating pain. Diagnosis remains 739.3, 722.10, 739.4 and 724.3.
Treatment Plan of Care	Spinal manipulation was performed to L4-5 and left sacroiliac. The patient is to return in two days for follow up. The patient was instructed to continue with his home icing protocol and to avoid any lifting or repetitive bending or twisting.

Documentation

Subsequent Visit

1. History *[S]*
2. Physical exam *[O]*
3. Treatment given *[P]*
4. Progress *[A]*

Claims

Claims

- Claims must be submitted for covered or *potentially* covered services
  - Providers may not charge for this paperwork
- Bill direct only for non-covered/statutorily-excluded services
- If beneficiary requests, providers must bill Medicare for non-covered services
  - Perhaps a requirement for Medicare Secondary Payers

Claims

- **Item 14** – Date of Initial Treatment/exacerbation of existing condition
- **Item 17/17B**—referring/ordering physician' name/NPI (if necessary)
- **Item 19**—x-ray as documentation of subluxation
  - 6 or 8 digit x-ray date with optional verbiage

Claims

- **Item 21**—diagnosis
  - No decimals or descriptions
  - Must be to highest level of specificity
  - Up to 12 diagnoses on paper claim
- Each region billed requires two diagnoses
  - Subluxation region listed as primary
  - Resulting disorder (condition) listed as secondary diagnosis
  - Do not bill for compensatory adjustments that are not causally related to the patient's symptoms

Modifiers

- AT: Active Treatment
  - Care is medically necessary
  - Only attached to 98940, 98941, 98942
- GA: Advanced Beneficiary Notice (ABN) on file
  - ABN is used when a covered service is expected to be denied due to lack of medical necessity
  - Only attached to 98940, 98941, 98942
- GZ: Advanced Beneficiary Notice (ABN) not on file
  - ABN should have been signed, but wasn't.
  - Only attached to 98940, 98941, 98942

Modifiers

- GX: Voluntary ABN signed
  - ABN voluntarily used to notify beneficiary of a non-covered service
  - Anything other than 98940, 98941, 98942
- GY: Non-covered service
  - Lets Medicare know that the services are statutorily excluded
  - Ensures a quick denial
  - Anything other than 98940, 98941, 98942
  - Not for maintenance care
- GP: Services delivered under an outpatient physical therapy plan of care
  - Required by some payers when billing for therapy services
  - Used in addition to GY

ABN

ABNs

- An ABN is a written notice that the health care provider gives to the beneficiary prior to rendering the service
  - Because the provider believes Medicare will not pay
  - If claim is denied for medical necessity, the ABN indicates that the beneficiary is financially responsible
- Used for maintenance therapy visits
- The form was revised in March 2011
  - The older form is not valid

[Practice Name]

[Address/Telephone]

Patient Name: _____ **Identification Number:** _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for the service(s) listed below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the the service(s) listed below.

Chiropractic Maintenance Care	Reason Medicare May Not Pay:	Estimated Cost per Treatment:
CPT codes 98940, 98941, 98942 or HCPCS code S8990	Spinal physical or manipulative treatment performed for **Maintenance** Care rather than restorative care is not a Medicare covered service.	$

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the service(s) listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the service(s) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the service(s) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the service(s) listed above. I understand with this choice I

ABN

- ABN must
  - State specific procedure (CMT) and estimated cost
  - Specific reason why provider believes CMS will likely deny payment
  - Signed/dated by beneficiary before service is rendered
- Form can only be changed
  - To add provider letterhead
  - To personalize sections A, B, C, D, E, F, and H

ABN Header

(A) Notifier(s):
(B) Patient Name: *Jane A Doe* (C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

- Blank A
  - Notifier's name, address and telephone #
- Blank B
  - Beneficiary's name as listed on Medicare card
- Blank C
  - Internal identification number (patient account)
    - **Cannot** use Medicare or social security number

ABN Body

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for ***(D)*** Service below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the ***(D)*** Service below.

(D) Service	***(E)*** Reason Medicare May Not Pay:	***(F)*** Estimated Cost:
•Write out specific service •Enter frequency and/or duration	•Enter detailed reason Medicare may not pay _____	•Enter reasonable charge (within $100)

ABN Options

(G) OPTIONS:	Check only one box. We cannot choose a box for you.

❑ **OPTION 1.** I want the ***(D)***_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the ***(D)***_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

❑ **OPTION 3.** I don't want the ***(D)***_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

- Provider **not** permitted to make this selection

ABN

Option 2 for maintenance 98940-98942

- Not for covered CMT with AT modifier
- Should be rare, not with every patient
- If patient later decides they want Medicare billed, but it is outside of timely filing, provider must refund
- Beneficiary (or representative) must choose one of the three options
  - The provider cannot choose for them

ABN Information/Signature

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
Jane Doe	10/01/13

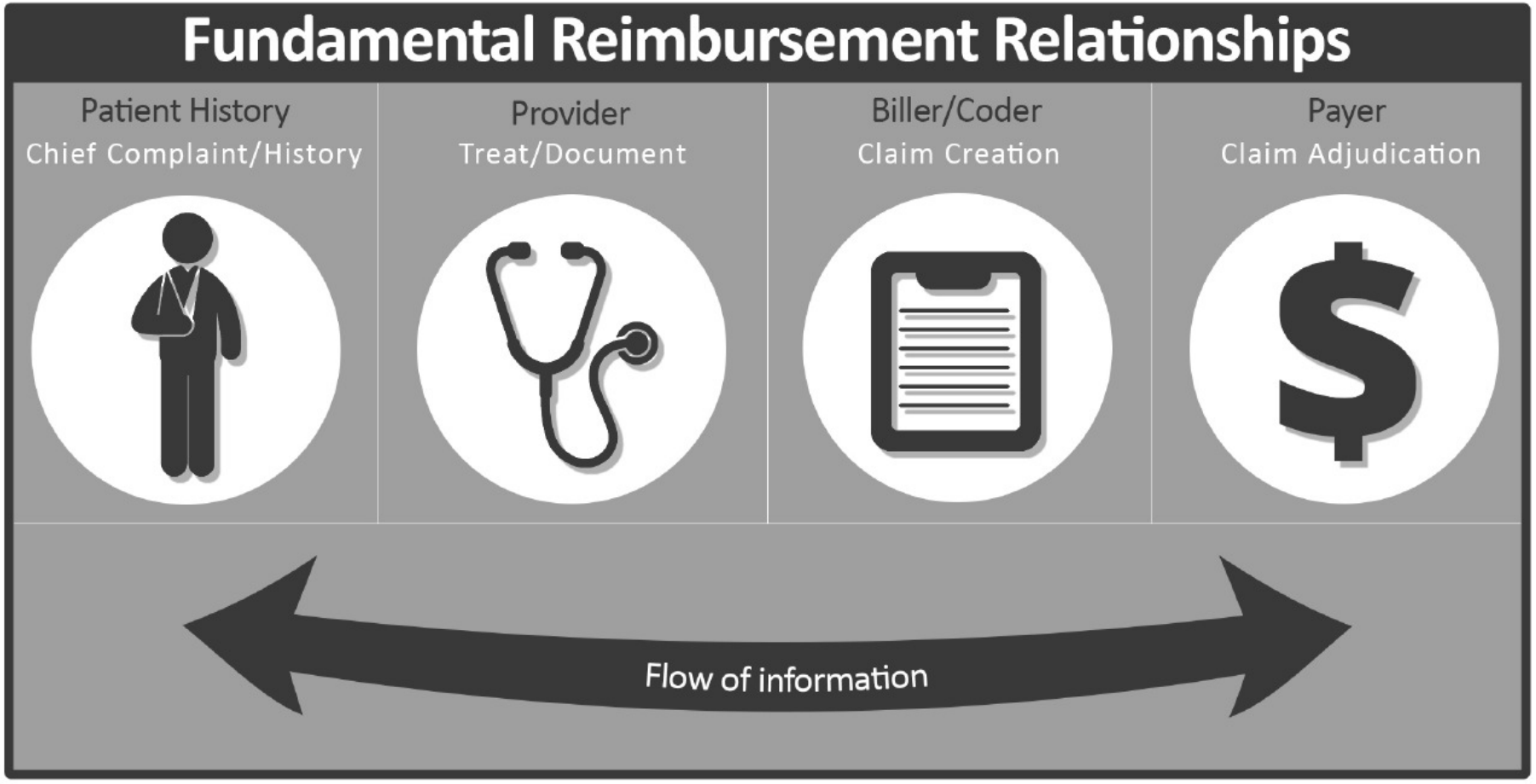
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

ABN

- Good for up to one year if:
  - It identifies all items/services and duration of period of treatment
  - No changes to treatment
  - Services are not added or deleted after treatment
- Any changes require a new ABN
- Some carriers advise to have patient sign and date back of ABN original at each visit.
- Instead of voluntary ABN for everything that is not covered, create your own form.

Figure 4.1


Fundamental Reimbursement Relationships
Patient History
Chief Complaint/History
Provider
Treat/Document
Biller/Coder
Claim Creation
Payer
Claim Adjudication
Flow of information

Takeaways

- Know what third parties want to see in your records
- Know what things could trigger audits in your records
- Document initial visits / assessments perfectly
- Document subsequent / treatment visits perfectly