HNS

Clinical Quality and Documentation Standards and Detection and Prevention of More Serious Health Issues

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Our Responsibility

We ALL have a responsibility to help make our healthcare system more efficient.

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Clinical Integration

HNS is a clinically integrated physician network (CIN).

A clinically integrated network is a collection of health care providers who commit to work together on the quality and cost-effectiveness of care for a specific population.

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HNS

In simple terms, *clinical integration is a continuous process that supports the* ***triple aim of health care****:*

- Improving safety and quality of care
- Reducing or controlling the cost of care
- Improving access to care and the overall patient experience

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What is Quality Healthcare?

Quality health care is
care that is safe, effective, patient-centered, timely, efficient, and equitable.

Quality in healthcare means
providing the care the patient needs when the patient needs it,
in an affordable, safe, and effective manner.

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What is Quality Healthcare?

At the core of 'quality healthcare' is the assumption that care will always be provided pursuant to generally recognized standards of medical and professional ethics, and the ethical and professional standards set forth by respective licensing board, the HNS Code of Ethics, HNS' Ethics and Professional Standards, and HNS Compliance Policies for Contracted Healthcare Professionals.

A core performance standard is that all healthcare professionals contracted with HNS shall, at all times, conduct business with **fairness, honesty, integrity, professionalism**, and consistent with the above noted standards, and all applicable laws and regulations.

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What is Quality Healthcare?
(Always Do the Right Thing, in the Right Way…)

Even in cases where interpretation of the policies, the HNS Code of Ethics, HNS Ethics and Professional Standards, or law may be ambiguous, permissive, or lenient, HNS expects its contracted healthcare professionals to **always do the right thing, in the right way,** and choose the course of honesty and integrity.

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HNS Best Practices

HNS has developed policies, programs and **best practices** which promote quality, safety, cost-efficiency, and which improve the overall patient experience.

The term "**best practice**" is often used to indicate what institutions, and well-regarded practitioners are doing. In short, a best practice is a method or practice that conventional wisdom suggests *is effective and will reliably lead to desired and/or improved outcomes.*

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HNS Best Practices

These **best practices** were developed, in part, with guidance from HNS' Professional Affairs Advisory Boards (PAAB). HNS PAABs are comprised of more than seventy chiropractic physicians practicing in North and South Carolina.

The standards contained herein are consistent with industry standards, federal and state laws, and the policies of HNS and its contracted payors.

These best practices may be periodically updated to address relevant changes in the industry, law, and payor and HNS policies.

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Important E/M Code Changes

Because of the significance of the new E/M code changes to this CE program, which were effective 01/01/21, before we get started on *Clinical Quality and Documentation Standards*, let's first review the important new **E/M code changes.**

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2021 E/M Changes

The American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) joined together to reshape evaluation and management (E/M) guidelines.

The primary goal of the new guidelines was administrative simplification.

The changes were effective 01/01/21.

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E/M Services

Evaluation and Management (E/M) Services are the most frequently billed CPT codes in all of medicine. The broad classification of E/M services include:

- **Office or other outpatient services**
- Hospital inpatient services
- Prolonged services
- Preventive medicine services
- Care management services

The revisions reviewed herein only apply to **office or other outpatient services**.

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Significant E/M Changes
Deletion of CPT 99201

Code **99201** has been deleted.

The decision to delete CPT code 99201 was made because both 99201 and 99202 require the same level of decision-making and are only differentiated by history and exam elements.

As of 01/01/21,
Payors no longer reimburse for this code.
(Report the applicable code using 99202-99205)

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Significant E/M Changes
History and Physical

The revised code descriptors state a "medically appropriate history and/or examination" is **required**.

While a history and examination is still REQUIRED for all E/M visits, **the *nature and extent of the history and examination is now determined by the treating physician* reporting the service.**

Regarding history -The care team may collect information and the patient (or caregiver) may supply information directly (*e.g.*, by portal or questionnaire) that is reviewed by the reporting physician or other qualified healthcare professional.

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Significant E/M Changes
History and Physical

While the provider's work in capturing the patient's pertinent history and performing a relevant physical exam contributes to both the time and medical decision making, *these elements alone should not determine the appropriate code level*.

The ***extent***
of the history and physical examination
is NOT an element in selection of the E/M code.

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Significant E/M Changes
Choice in Basis of E/M Code Selection

Importantly

Physicians may now use either
total time spent on the date of the E/M service
OR
medical decision-making (**MDM**)
as the basis for E/M code selection.

(More on This Coming Up…)

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Medical Decision-Making (MDM) as the Basis for Code Selection

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MDM as Basis for Code Selection

Four types of medical decision-making are recognized:

- Straightforward
- Low
- Moderate
- High

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Medical Decision-Making (MDM)

Medical decision-making includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option.

Medical decision-making is based on the following 3 factors:

1) The number and complexity of problems addressed at the encounter;

2) The amount and/or complexity of data to be reviewed and analyzed; and,

3) The risk of complications and/or morbidity and mortality of patient management.

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Medical Decision-Making (MDM)

To qualify for a particular level of medical decision-making,
2 out of 3
of the required elements *must be met or exceeded*.

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MDM as Basis for Code Selection

The concept of the level of medical decision-making does not apply to code 99211.

If the provider performs the E/M service, 99211 should not be used.
(Instead, report 99212-99215.)

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MDM as the Basis for Code Selection for 99204, 99214, 99205, 99215

When **MDM** is the basis for code selection, in chiropractic, it can be difficult to meet the requirements to appropriately report these codes, but when time is the basis for code selection, it is likely that you will frequently meet the time requirements to appropriately report/bill these codes!

99204
99205
99214
99215

If you DO choose to utilize medical decision-making as the basis for code selection, (rather than time), **ensure your documentation fully substantiates the appropriateness of reporting these codes!**

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Medical Decision-Making (MDM) AMA Decision-Making Table

The AMA has published an excellent article (*for personal use only*) which includes an excellent ***medical decision-making table*** to help you determine the most appropriate code to report.

The table includes the 4 levels of medical decision making (straightforward, low, moderate, high) and the 3 elements of medical decision-making.

As previously noted, to qualify for a particular level of medical decision- making, 2 of the 3 elements for that level of medical decision making must be met or exceeded. The table illustrates the needed requirements for each level of decision-making.

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Medical Decision-Making AMA Decision-Making Table

The article is titled
"*CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes*".

This article (and the decision-making table) can be obtained by copying and pasting the web address below to your browser:

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

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Time
as the Basis
for Code Selection

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Time as Basis for Code Selection

Time alone
may be now be used as the only basis for selecting the appropriate E/M code.

The time calculations are for the
actual time spent by the provider.

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Time as Basis for Code Selection

Time is defined as
actual total time
(including both face-to face, and non-face-to-face work)
spent by the provider
on the day of the E/M encounter.

Each code has a specific range of time.
You must spend the minimum amount of time shown in each range to report the code

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Time as the Basis for Code Selection (Table of Minutes)

Code	Total Time (minutes) on the date of the encounter that must be met or exceeded
~~99201~~	Code deleted
99202	15
99203	30
99204	45
99205	60

99211	(Time removed)
99212	10
99213	20
99214	30
99215	40

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Time as the Basis for Code Selection Face-to-face Time

When calculating TOTAL time spent on the day of the encounter, you may include face–to-face time spent, such as:

- ✓ Obtaining a history.
- ✓ Performing a medically appropriate examination and/or evaluation.
- ✓ Discussion - Informed Consent
- ✓ Presenting Report of Findings.
- ✓ Counseling and educating the patient, family, and/or caregiver.

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Time as Basis for Code Selection: Report of Findings (ROF)

Again, whenever time is the basis for code selection, you will use the total time spent **on the day of the encounter.**

- If your Report of Findings is done *on the same day as the E/M visit*, you **MAY** include the time spent on ROF when calculating total time.
- If your Report of Findings is done *on a day other than the day of the E/M visit* you **MAY NOT** include the time spent on the ROF when calculating total time.

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Time as the Basis for Code Selection
Non-face-to-face Time

When calculating TOTAL time spent
on the day of the encounter,
you may include non-face–to-face time spent, including:

- ✓ Reviewing tests in preparation of a patient visit
- ✓ Reviewing a separately obtained history
- ✓ Review of imaging studies, tests, and/or records brought by patient
- ✓ Ordering tests, procedures, etc.
- ✓ Creating treatment plan
- ✓ **Preparing Report of Findings**.
- ✓ **Documenting information in the healthcare record.**

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Time as the Basis for Code Selection
Non-face-to-face Time

When calculating TOTAL time spent
on the day of the encounter,
you may also include non-face–to-face time spent, such as:

- ✓ Referring and communicating with other healthcare professionals (coordination of care), when not separately reported with other CPT codes.
- ✓ Independently interpreting tests NOT separately reported with other CPT codes. (More about this coming up …)
- ✓ Communicating results of tests NOT separately reported with other CPT codes. (More about this coming up …)

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Time as the Basis for Code Selection
Staff Time

In calculating total time spent on the day of the encounter, time does **NOT** include time for activities normally performed by clinical or clerical staff.

Whether face-to-face, or non-face-to-face, total time can only reflect time spent by the provider (not staff time).

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Time as Basis for Code Selection: 99204, 99214, 99205, 99215

When TIME is the basis for code selection, don't shy away from reporting/billing these E/M codes!

99204	(45-59 minutes)
99205	(60-74 minutes)
99214	(30-39 minutes)
99215	(40-54 minutes)

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Time as Basis for Code Selection

Using **total time**
(on the day of the encounter)
as the basis for code selection allows us to be more appropriately paid for the work and time spent providing E/M services to our patients.

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A Shorter Prolonged Service Code

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Significant E/M Changes
New Shorter Prolonged Service Code

A shorter prolonged services code (**99417**) has been added, effective 01/01/21, which will capture physician time in 15-minute increments.

CPT Code Description for 99417:
Prolonged office or other outpatient E/M service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, **on the date of the primary service**; each 15 minutes

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Significant E/M Changes
New Shorter Prolonged Service Code

This code may ONLY be used when **TIME** *is the basis for code selection*. This code would ONLY be reported with **99205** and **99215**.

99205: report only when total time exceeded 74 minutes by 15 minutes.

99215: report only when total time exceeded 54 minutes by 15 minutes.

Because it is unlikely the total time (shown above) for 99205 and 99215 would be exceeded for a chiropractic E/M visit, payors would not expect to see CPT 99417 utilized with any degree of frequency.

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Services Reported Separately

(When time is the basis for Code Selection)

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Time as Basis for Code Selection
Services Reported Separately

When reported separately under a specific CPT code,
the actual performance and/or interpretation of diagnostic tests/studies
during a patient encounter
are NOT included in
determining the level of E/M service.

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Services Reported Separately
(Radiology Services)

When a provider takes (or supervises) an x-ray in his/her facility, interprets the study and writes a report, the appropriate radiology code must be reported, and is reported *separate from the applicable E/M code*.

Since x-rays will be reported separately,
the time spent taking the x-rays, interpreting the x-rays, and writing the report
CANNOT
be included in calculating total time of the E/M encounter.

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Services Reported Separately
(Radiology Services)

Example: (Separately reported)
Dr. A examines a new patient with a complaint of low back and lower extremity pain. He takes lumbosacral x-rays (72100), interprets the x-rays and documents the findings in the patient record. On the same day, he also does a ROF, followed by a 3-spinal region adjustment.

In addition to the appropriate E/M code,
Dr. A would also
separately report CPT codes 98941 and 72100.

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Services NOT
Reported Separately

(When time is the
basis for Code Selection)

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Services NOT Reported Separately

If a test/study is independently interpreted to manage the patient as part of the E/M service, *and is NOT separately reported with a specific CPT Code*, then provided the interpretation is done on the same DOS as the E/M service, the time spent interpreting and discussing the test/study with the patient **CAN be counted when calculating total time**.

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Services NOT Reported Separately

Example A: (Not separately reported)
A new patient comes in to see Dr. A for his initial evaluation and brings a copy of a recent CT of his spine.

Since Dr. A did not order, take or interpret the CT, he will not report (bill) the review of the CT using a separate CPT code.

Dr. A does NOT perform CMT on this visit. As part of Dr. A's evaluation of the patient, he reviews the CT scan. However, **since Dr. A will not report (bill) a CMT code related to the CT scan, he CAN include the time he spent reviewing/discussing the scan when calculating the total time spent on this E/M visit.**

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Separately Reported When CMT Performed

Example B: (Options)
An established patient comes in for treatment, and the visit will include spinal and/or extra spinal manipulation. The patient brings in an MRI/CT scan recently ordered by his PCP and wants you to review it.

Assuming Chiropractic Manipulative Treatment (CMT) is performed, the manipulation will be billed using the applicable CMT code. Since the pre-service component of CMT procedures (98940-98943) includes chart review, ***imaging review, test interpretation***, and care planning, **time spent reviewing the MRI/CT would NOT be counted when calculating total time for an E/M service.**

However, if there has been a **new occurrence (or exacerbation of existing condition) since the last visit**, and/or if the MRI/CT indicates the need for an E/M service on that date, then the review of the MRI/CT would be part of that E/M service, and **the time spent reviewing/discussing the MRI/CT would be included in your calculation of total time for that E/M visit, since you would not be reporting the review of the MRI/CT under a separate CPT code.**

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X-rays Taken Elsewhere

Let's Look at Examples

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X-rays Taken Elsewhere

Example:
Dr. A does not have x-ray in his office, and has an arrangement with Dr. B down the street to take and interpret x-rays for Dr. A, and Dr. A has agreed to pay Dr. B a fee for his services.

Dr. A has a new or established E/M service scheduled for today. Dr. A wants films on the patient and sends the patient to Dr. B and asks him to do radiologic examination, spine (CPT 72100).

Dr. B takes and interprets the x-rays and sends a written report to Dr. A with his findings.

- **Dr. B reports/bills the *global* x-ray code (72100).**
- **Dr. A does not separately report a specific CPT code for the interpretation of the x-rays.**

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X-rays Taken Elsewhere

Example (cont.):
If Dr. A receives and reviews the report (and/or x-rays and report) **on the SAME DAY he/she is performing the E/M service to the patient**, Dr. A **CAN** include the time spent reviewing the film/report in the calculation of total time spent during the E/M encounter, *provided Dr. A is not also providing a CMT service on the same patient on the same date*.

If Dr. A receives and reviews the report **on a day different from the date of the E/M Service, OR also performs CMT *on the day the report is reviewed.*** Dr. A **CANNOT** separately report the time spend on the review, since 1) the review was not done on the date of the E/M service and/or 2) the review would fall under the pre-service work of the CMT service, which would be separately reported.

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Let's Review:
Code Selection for New & Established Patients

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Time or MDM

You may now choose between using
total TIME on the date of the EM service
OR
MDM as the basis for E/M code selection.

Time:
Each code has a specific range of time. Time will be defined as total actual time spent (including non-face-to-face) on the day of the EM encounter. (Time can include documenting in the healthcare record and ROF *if done on the date of the encounter.*)

Whether face-to-face, or non-face-to-face, total time can only reflect time spent by the provider (**not staff time**).

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New Patient (99201)

99201 has been deleted.

Effective 01/01/21,
Payors will NOT reimburse for this code.

(Report the most appropriate code using 99202-99205)

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Code Selection
New Patient (99202)

99202

Time (basis for code selection)
When using time for selecting the E/M code, **15-29 minutes** of total time must be spent **on the date of the encounter (including both face-to-face, and non-face-to-face time)**. (Requires a medically appropriate history and exam)

Medical decision-making (basis for code selection)
Requires 1) a medically appropriate history and/or examination and 2) **straight forward medical decision making.**

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Code Selection
New Patient (99203)

99203

Time (basis for code selection)
When using time for selecting the E/M code, **30-44 minutes** of total time must be spent **on the date of the encounter (including both face-to-face, and non-face-to-face time)**. (Requires a medically appropriate history and exam)

Medical decision-making (basis for code selection)
Requires 1) a medically appropriate history and/or examination and 2) **low level of medical decision making.**

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Code Selection
New Patient (99204)

99204

Time (basis for code selection)
When using time for selecting the E/M code, **45-59 minutes** of total time must be spent **on the date of the encounter (including both face-to-face, and non-face-to-face time)**. (Requires a medically appropriate history and exam)

Medical decision-making (basis for code selection)
Requires 1) a medically appropriate history and/or examination and 2) **moderate level of medical decision making.**

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Code Selection
New Patient (99205)

99205

Time (basis for code selection)
When using time for selecting the E/M code, **60-74 minutes** of total time must be spent **on the date of the encounter (including both face-to-face, and non-face-to-face time)**. (Requires a medically appropriate history and exam)

Medical decision-making (basis for code selection)
Requires 1) a medically appropriate history and/or examination and 2) **high level of medical decision making.**

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Established Patient (99211)
(Do not use)

99211

This is a low-level E/M visit which
does not require a provider to be present
with the patient,
nor does it require a history, examination or any type of medical decision-making.

This code should NOT be utilized when the provider is performing an evaluation of an established patient. **(Instead, use 99212-99215).**

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Code Selection
Established Patient (99212)

99212

Time (basis for code selection)
When using time for selecting the E/M code, **10-19 minutes** of total time must be spent **on the date of the encounter (including both face-to-face, and non-face-to-face time)**. (Requires a medically appropriate history and exam)

Medical decision-making (basis for code selection)
Requires
1) a medically appropriate history and/or examination and
2) **straightforward medical decision making**.

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Code Selection
Established Patient (99213)

99213

Time (basis for code selection)
When using time for selecting the E/M code, **20-29 minutes** of total time must be spent **on the date of the encounter (including both face-to-face, and non-face-to-face time)**. (Requires a medically appropriate history and exam)

Medical decision-making (basis for code selection)
Requires 1) a medically appropriate history and/or examination and 2) **low level of medical decision making.**

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Code Selection
Established Patient (99214)

99214

Time (basis for code selection)
When using time for selecting the E/M code, **30-39 minutes** of total time must be spent **on the date of the encounter (including both face-to-face, and non-face-to-face time)**. (Requires a medically appropriate history and exam)

Medical decision-making (basis for code selection)
Requires 1) a medically appropriate history and/or examination and 2) **moderate level of medical decision making.**

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Code Selection
Established Patient (99215)

99215

Time (basis for code selection)
When using time for selecting the E/M code, **40-54 minutes** of total time must be spent **on the date of the encounter (including both face-to-face, and non-face-to-face time)**.
(Requires a medically appropriate history and exam)

Medical decision-making (basis for code selection)
Requires 1) a medically appropriate history and/or examination and 2) **high level of medical decision making.**

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E/M Services:

Documentation Requirements

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E/M
Documentation Requirements

Whether you use
time or **medical decision-making**,
as the basis for code selection
the ***medical necessity***
for what you do
must be substantiated in the healthcare record

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MDM is the Basis for Code Selection Documentation Requirements:

In addition to the standard documentation required for all healthcare encounters, when **MDM** is the basis for code selection, **your documentation must clearly support the specific E/M Code billed.**

Medical decision-making is based on the following 3 factors:

1) The number and complexity of problems addressed at the encounter;
2) The amount and/or complexity of data to be reviewed and analyzed; and,
3) The risk of complications and/or morbidity and mortality of patient management.

To qualify for a particular level of medical decision-making, **2 out of 3 of the required elements *must be met or exceeded.***

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Time is the Basis for Code Selection Documentation Requirements:

In addition to the standard documentation required for all healthcare encounters, when **TIME** is the basis for code selection, **your documentation must indicate the total time spent during the E/M encounter** (*and should include both face-to-face time spent with the patient as well as non-face-to-face time spent on the same day as the encounter.)*

Your documentation should make clear ***that time was the basis for the code selected.***

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Examples of Documentation

When **TIME** is the Basis for Code Selection

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Initial Exam
(Example of Documentation)

Mr. X entered the office today (05/16/21) for complaint(s) resulting from an accident involving two automobiles.

The patient met with office support staff for further questioning about his symptoms and complaints. This information, along with patient intake questionnaires were reviewed an annotated by the examining provider (**8 minutes**). The completed questionnaire is in the patient's permanent digital file and available for review.

Subjective: Patient complains at the time of the accident he felt discomfort at the abdomen, back, chest, head, neck, right upper extremity and left upper extremity and supplemental complaints of breathing difficulty, rib pain, stomach pain, headaches, tightness, soreness, sleeping difficulty, tiredness, loss of appetite and low energy. Mr. X states that since the date of the accident his overall condition has not changed, and reports deteriorated daily functioning.

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Initial Exam
(Example of Documentation)

Mechanism of Injury:
Patient was positioned as the front seat passenger of the vehicle, and was wearing seat belts; air bag did not deploy. Seat he was sitting in was broken during impact. He states prior to impact headrest was in 'low' position relative to the head and the head did come in contact with head restraint. States he was looking straight ahead at impact and did strike back of head/neck, front of head and right side of head against dashboard, door, headrest, seat, and window. Patient relayed he did receive a head injury, but did not lose consciousness.

Estimated speed of patient's vehicle was between 40 and 60 mph. The other vehicle was moving at an estimated speed excess of 65 mph. The patient's vehicle was totaled and removed from the scene. Police arrived at scene and an accident report was completed. EMS personnel were present. Patient was driven to XXX Hospital ER by family and had CT scans of head, neck, chest, pelvis, abdomen, and was prescribed medication and released.

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Initial Exam
(Example of Documentation)

Chief Complaint: Patient reports acute pain of posterior head, posterior cervical (neck), thoracic, lumbar, chest, sternal and abdominal pain due to the impact of auto accident, and deteriorating function

VAS: Complaint has stayed the same since onset, pain scale is 7/10 (10/10 most severe)

Frequency/Quality: Constant discomfort described as aching, burning, deep, dull, sharp, stabbing/throbbing, stiffness and tightness

Radiation of Symptoms: Currently non-radiating

Modifying Factors: Relieved by prescription medication and aggravated by: any movement, bending, carrying or lifting, changing positions, coughing or sneezing, getting out of bed, car, or chair, looking over shoulder, lying down, getting or falling asleep, pushing, pulling, or reaching, raising arm above shoulder, self care, sitting in car or chair, squatting or bending, standing, walking or running and working at desk or computer.

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Initial Exam
(Example of Documentation)

Previous Episodes: Denies past episodes

Previous Care: Received medical care as described above as care for this condition

Recent Diagnostic Tests: Confirms recent diagnostic testing

ADL Functional Deficits: Explains sitting, walking are difficult. Sleeping has become difficult when lying down, difficulty rising out of bed, getting to sleep, staying asleep and changing position in bed (rolling) when he does this for more than 1 minute.

Patient subjective goal(s): Explains personal goal for starting treatment is to have no functional limitations

No additional concerns relayed by patient.

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Initial Exam
(Example of Documentation)

Systems Review: reports status of condition(s) below which may relate to complaints

Musculoskeletal: Other than presenting musculoskeletal complaints patient reports arthritis
Neurological: Other than presenting complaints patient reports no neurological concerns
Head & ENT: Reports no head and/or ENT concerns
Cardiovascular: Reports high blood pressure
Respiratory: Reports no respiratory concerns
Gastrointestinal: Reports no gastrointestinal concerns
Genitourinary: Reports no genitourinary concerns
Endocrine: Reports diabetes
Derma./Hemo: Reports no dermatological / hemopoietic concerns
Allergy/Sensitivity: none

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Initial Exam
(Example of Documentation)

Past Health History:

Surgery: shoulder- left and shoulder- right, left and right knee replacement, cyst removed from throat and right ear.

Illnesses: severe osteoarthritis, diabetes, high blood pressure and high cholesterol.

Medications: prescription meds for hypertension and high cholesterol, over-the-counter muscle relaxers.

Accidents: multiple slip and falls, resulting in permanent injury or disability and resulting in hospitalization(s)

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Initial Exam
(Example of Documentation)

Family and Social History:

Family History: cancer, diabetes, heart disease, high blood pressure and high cholesterol

Employment Status: Reports fully disabled

Social Habits: Reports drinks caffeine; non-smoker

Exercise Habits: Reports exercise 3+ times a week

Diet and Nutrition: Reports daily supplements

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Initial Exam
(Example of Documentation)

Presentation: is a 59 year old Male. He was born 1/12/1959. He is described as cooperative, in pain, mentally alert and overweight.

Objective:
Examination Findings:

Vital Signs: vital signs were taken.
He is 71.5" tall.
He weighs 287 pounds.
His blood pressure was taken in the standing and the observed measurement was **149/101.**
His pulse measured 79 bpm.

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Initial Exam
(Example of Documentation)

Objective:
The following examinations/tests/studies were performed on Mr. X to evaluate his current complaint(s).

Range of Motion (ROM) testing
Active range of motion testing procedures were performed today using the ZERO-NEUTRAL, GRAVITY-BASED SFTR (Sagittal Frontal Transverse Rotation) Method from the AMA Guidelines to the Evaluation of Permanent Impairment, Fifth Ed., 2001.

The individual test measurements and their calculated impairments are objective tests and will be repeated periodically to measure patient progress toward treatment goals and to help determine when MMI is reached.

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Initial Exam
(Example of Documentation)

Objective:

Range of Motion Testing. Cervical range of motion was measured and the following was found:
(+ = mild pain ++ = moderate pain +++ = severe pain)

Flexion	(Normal 45 degrees):	40+
Extension	(Normal 45 degrees):	18+
L. Rotation	(Normal 80 degrees):	22++
R. Rotation	(Normal 80 degrees):	18++
L. Lateral Flexion	(Normal 45 degrees):	12++
R. Lateral Flexion	(Normal 45 degrees):	10++

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Initial Exam
(Example of Documentation)

Objective:

Range of Motion Testing. Lumbar range of motion was measured and the following was found:
(+ = mild pain ++ = moderate pain +++ = severe pain)

Flexion	(Normal 90 degrees):	45+
Extension	(Normal 25 degrees):	10+
L. Rotation	(Normal 30 degrees):	20
R. Rotation	(Normal 30 degrees):	20
L. Lateral Flexion	(Normal 25 degrees):	10+
R. Lateral Flexion	(Normal 25 degrees):	10+

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Initial Exam
(Example of Documentation)

Objective:

Cervical compression:
A Cervical Compression Test was performed on this patient in order to localize the cervical pain. Downward pressure was applied to the top of the head with a positive test resulting in radiating spinal pain.

Mr. X tested positive with pain. An increase in pain was noted in the left cervical and right cervical region that was rated as a Grade 3: Severe pain observed and reported. His movement was observed to be painful.

78

Initial Exam
(Example of Documentation)

Objective:
Kemp's Test was positive bilaterally.

Spinal Palpation: Digital palpation of the patient's spine and extremities revealed the following areas of subluxations: cervical and thoracic.

Static and motion palpation reveals areas of spasm, hypomobility and end point tenderness indicative of subluxation at right C2, right C4, left C6, left C7, right T6, right T7, right T8, right T9, right T10, right T11, right T12 and right L1.

Palpation of the muscles revealed hypertonicity in the following areas: cervical, mid thoracic, lower thoracic and lumbar.

79

Initial Exam
(Example of Documentation)

Objective:
X-ray studies of the cervical spine in the A-P, A-P Open Mouth, and Lateral views were performed 5/16/21 at X Chiropractic. P.A. Films were read by Dr. X, DC, and revealed the following:C2 spina bifida anomaly; C2, C4 right body rotation; C6, C7 left body rotation; severe goose neck lordosis; moderate left C3-C7 spurring /degeneration, possible ankylosis; moderate anterior spurring C6-C7.

X-ray studies of the thoracic spine in the A-P and Lateral views were performed 5/16/21 and read by Dr. X, DC and revealed the following: severe right ankylosis T7-L 1; T6-L 1 right body rotation.

I also reviewed a CD copy of CT scans of his head, neck, chest, abdomen taken at the ER, as well as the ER physician notes from the date of the accident.

80

Initial Exam
(Example of Documentation)

Functional Assessments were completed today by the patient:

Neck Pain Disability Index Questionnaire rendering a score or percentage of 56 which demonstrated functional deficits or disability.

Low Back Disability Questionnaire (Revised) rendering a score or percentage of 48 which demonstrated functional deficits or disability.

Oswestry Disability Questionnaire rendering a score or percentage of 46 which demonstrated functional deficits or disability.

Headache Disability Index Questionnaire rendering a score of percentage of 34 which demonstrated functional deficits or disability.

81

Initial Exam
(Example of Documentation)

Upon consideration of the information available, I have established the following diagnoses:

S13.4XXA	Sprain of cervical ligts, initl.
S23.3XXA	Sprain of ligts of thoracic spine
M50.323	Other cervical disc degeneration at C6- C7 level
M48.14	Ankylosing hyperostosis [Forestier], thoracic region
M99.01	Seg and somatic dysf of cervical reg
M99.02	Seg and somatic dysf of thoracic reg
M99.03	Seg and somatic dysf of lumbar reg
M54.2	Cervicalgia
M54.6	Pain in thoracic spine

82

Initial Exam
(Example of Documentation)

Assessment:

A detailed initial exam was performed today (**15 minutes**).

Patient is in fair health, with no contraindications to chiropractic care, and is expected to make good progress and recovery with some residuals.

Based on his history of severe osteoarthritis and severity of initial episode of injury, it is reasonable to believe that his recovery may take longer than an average patient with an uncomplicated case.

He is currently in the acute phase of care.

83

Initial Exam
(Example of Documentation)

Plan

Short Term Goals:

Treatment goals include the following; 50% reduction in symptoms, 50% reduction of pain and 50% increase in ability to perform impacted ADL's, and 10% improvement in cervical and lumbar ROM within 4 weeks.

Based on examination findings, the initial plan will be 3 visits per week for 4 weeks. Unless there is a basis for change, the treatment plan will remain unchanged until the 12th visit or approximately 4 weeks from today (whichever comes first).

Changes in condition for better or worse or any new injury will be noted.

84

Initial Exam
(Example of Documentation)

Informed Consent
Probability and significance of any risks associated with the proposed treatment as well as other treatment options were discussed with Mr. X today. He was provided an opportunity to ask questions. It was clear he understood the plan, cost of care, and decided to move forward with treatment.

He signed consent for treatment of injuries sustained as the result of the accident that occurred on 5/11/21, which is in the patient's permanent digital file and available for review.

85

Initial Exam
(Example of Documentation)

Time was the basis for E/M code selection for today's detailed initial exam (**99204**) and is based on a **total time spent today of 58 minutes.**

Face-to-face time:
30 minutes: performed examination of all areas of chief complaints. I reported the findings (ROF) to the patient, reviewed the proposed treatment plan, cost of care, counseled patient re potential risks of care, other tx options, BP results, and recommended PCP referral re BP.

Non-face-to-face time:
8 minutes: Information obtained by staff, and patient intake questionnaires were reviewed and annotated by the examining provider.

20 minutes: Reviewed the patient's hx, ordered tests/studies and reviewed all clinical exam findings (subjective and objective), including CT scans of head, neck, chest and abdomen from day of accident, and the ER physician notes from the ER visit, prepared tx plan, and completed documentation of today's visit.

86

Initial Exam
(Example of Documentation)

Treatment:
Electrical stimulation in the form of premodulated current was applied to both the thoracic and lumbar regions. The cycle time set at continuous. The beat frequency set at 80- 150 Hz. Electric muscle stimulation was performed for 8 minutes on each affected region *to reduce spasm, improve range of motion, and alleviate pain.*

Myofascial Rapid Release was applied to the bilateral traps and levator scapulae muscles to *increase range of motion and decrease muscle spasm* (for 5 minutes). While in the acute phase, continued need for this procedure will be assessed on follow-up visits.

87

Initial Exam
(Example of Documentation)

Treatment

Adjustments were delivered in the following manner: Specific chiropractic spinal adjustments including the following techniques: Diversified technique and ProAdjustor were performed in 3-4 regions at the following spinal levels C1, C2, C3, CS, C6, C7, T1, T2, T3, T4, T5, T6, T7, T8 and L1.

The patient will return in 2 days for follow-up care.

PCP Referral: Because the patient is on prescribed Rx for hypertension and his BP today is **149/101,** the patient was directed to promptly contact his PCP, advise him/her of the BP reading today, and to comply with PCP's advice or guidance.

88

Re-exam
(Example of Documentation)

As a follow up to the initial detailed examination performed 5/16/2021, a follow up detailed reexamination was performed today (6/11/2021).

The patient met with office support staff for further questioning about his symptoms and major complaints and completed new OAs. This information, along with patient intake questionnaires, was reviewed and annotated by the examining provider (**5 minutes**). The completed questionnaires are in the patient's permanent digital file and available for review.

89

Re-exam
(Example of Documentation)

Subjective:

He reported that the following symptoms have diminished since he began treatment; headaches, chest pain, upper back pain. Cervical pain present but improved. Overall, he feels his condition is significantly better. However, he complains of occasional dull, aching and tightness discomfort in the mid back. He rated the intensity of discomfort, using a VAS, as a level 3 on a scale of 1 to 10, with 10 being the most severe. The discomfort was reported to increase with prolonged sitting and coughing / sneezing. The discomfort was reported to decrease with rest and chiropractic care.

He also complained of intermittent sharp/ shooting, dull/aching discomfort in the low back. He rated the intensity of discomfort, using a VAS, as a level 9 on a scale of 1 to 10 with 10 being the most severe. The discomfort was reported to increase with movement and coughing / sneezing.

90

Re-exam
(Example of Documentation)

Objective:
Vital Signs:
He is 71.5" tall.
He weighs 283 pounds.
His blood pressure was taken in the standing and the observed measurement was **130/90.**
His pulse measured 78 bpm.

91

Re-exam
(Example of Documentation)

Objective:
Range of Motion (ROM) testing
Active range of motion testing procedures were performed today using the ZERO-NEUTRAL, GRAVITY-BASED SFTR (Sagittal Frontal Transverse Rotation) Method from the AMA Guidelines to the Evaluation of Permanent Impairment, Fifth Ed., 2001.

The individual test measurements and their calculated impairments are objective tests that objectively measure patient progress toward treatment goals and to help determine when MMI is reached.

92

Re-exam
(Example of Documentation)

Objective:
Cervical range of motion was measured, and the following was found:

Flexion	(Normal 45 degrees):	was 40	now 45
Extension	(Normal 45 degrees):	was 18	now 35
Left Rotation	(Normal 80 degrees):	was 22+	now 50
Right Rotation	(Normal 80 degrees):	was 26+	now 45
Left Lateral Flexion	(Normal 45 degrees):	was 12+L	now 25+
Right Lateral Flexion	(Normal 45 degrees)	was 10+	now 25+

The above findings, coupled with updated OA scores, indicate significant positive improvement since his initial exam on 05/16/21.

93

Re-exam
(Example of Documentation)

Objective:

Range of Motion Testing. Lumbar range of motion was measured and the following was found:
(+ = mild pain ++ = moderate pain +++ = severe pain)

Flexion	(Normal 90 degrees):	was 45+ now 70
Extension	(Normal 25 degrees):	was 10+ now 20
L. Rotation	(Normal 30 degrees):	was 20 now 25
R. Rotation	(Normal 30 degrees):	was 20 now 30
L. Lateral Flexion	(Normal 25 degrees):	was 10+ now 20
R. Lateral Flexion	(Normal 25 degrees):	was 10+ now 20

The above findings, coupled with updated OA scores, indicate significant positive improvement since his initial exam on 05/16/21.

94

Re-exam
(Example of Documentation)

Objective:

Kemp's Test was positive bilaterally.

The patient completed the following outcome assessment form and the results were compared to those completed during the initial exam to measure patient progress toward treatment goals and to help determine when MMI is reached.

Oswestry Disability Questionnaire functional outcome assessment tool with beginning score of 46% and goal of 10% or better. The current overall score is 30% with an overall change of 16%.

Neck Pain Disability Index Questionnaire functional outcome assessment tool with beginning score of 56% and goal of 10% or better. The current overall score is 35% with an overall change of 21%.

95

Re-exam
(Example of Documentation)

Objective:

A re-exam of previous examination positives was performed 6/11/21 on Mr. X. Upon consideration of the information available the diagnoses have changed to:

M99.01	Seg and somatic dysf of cervical reg
M99.02	Seg and somatic dysf of thoracic reg
M99.03	Seg and somatic dysf of lumbar reg
M54.2	Cervicalgia
M50.323	Other cervical disc degeneration at C6- C7 level
M48.14	Ankylosing hyperostosis [Forestier], thoracic region
M54.6	Pain in thoracic spine.

96

Re-exam
(Example of Documentation)

Assessment

An initial examination was performed on 5/16/21. Today, a detailed re-examination was performed (**10 minutes**).

In consideration of the subjective and objective clinical findings from today's exam, re-evaluation of complaints, outcome scores and my examination findings for this condition, the patient's progress is good, but continued treatment is necessary *to reach objective treatment goals and MMI.*

The new treatment plan will be modified to decrease visit frequency.

97

Re-exam
(Example of Documentation)

Time was the basis for E/M code selection for today's detailed exam (**99214**) and is based on a **total time spent today of 35 minutes.**

Face-to-face time:
15 minutes: a detailed re-exam was performed today. I reviewed reduction in complaints/symptoms, functional gains, progress towards tx goals, and revised treatment plan with the patient.

Non-face-to-face time:
5 minutes: The patient met with office support staff for further questioning about patient's complaints and symptoms. Information obtained by staff, and patient intake questionnaire, was reviewed and annotated by the examining provider.

15 minutes: Reviewed the patient's complaints, ordered tests/studies and reviewed all clinical exam findings (subjective and objective), revised treatment plan. Completed documentation for today's re-exam.

98

Re-exam
(Example of Documentation)

Plan

Short Term Goals:

Our initial goals included the following; 50% reduction in symptoms, 50% reduction of pain and increased ability to perform ADLs and 10% improved cervical and lumbar ROM within 3-4 weeks. While significant progress has been made, more treatment is needed to reach initial treatment goals.

Our goal will be to decrease visit frequency without losing progress made and look for him to reach MMI within the next 4 weeks.

The treatment plan is revised to 2 visits every week for 2-3 weeks, based on objective findings, may extend for 2 more weeks. Changes in condition for better or worse or any new injury will be noted.

99

Re-exam
(Example of Documentation)

Treatment:
Electrical stimulation in the form of premodulated current was applied to both thoracic and lumbar regions. The cycle time set at continuous. The beat frequency set at 80- 150 Hz. Electric muscle stimulation was performed for 8 minutes on each affected region *to reduce spasm, improve range of motion, and alleviate pain.*

Adjustments were delivered in the following manner: Specific chiropractic spinal adjustments including the following techniques: Diversified technique and ProAdjustor were performed in 1-2 regions at the following spinal levels C1, C2, C3, C5, C6. C7, T1, T2, T3. T4, T5, T6, T7, T8 and L1.

The patient will return in 4 days for follow-up care.

100

Final Re-exam
(Example of Documentation)

An initial detailed exam was performed on 05/16/21 and a follow-up re-exam was performed on 6/11/2021. Today, (07/15/21) a re-exam was performed.

The patient met with office support staff for further questioning about symptoms and complaints and completed new OAs. This information, along with patient intake questionnaires, was reviewed an annotated by the examining provider (**5 minutes**). The completed questionnaires are in the patient's permanent digital file and available for review.

Subjective:
Patient reports all symptoms associated with his initial complaints have resolved, and he has regained function and states he feels great.

101

Final Re-exam
(Example of Documentation)

Objective:

Vital Signs:
He is 71.5" tall.
He weighs 283 pounds.
His blood pressure was taken in the standing and the observed measurement was 130/90.
His pulse measured 78 bpm.

102

Final Re-exam
(Example of Documentation)

Objective:
Range of Motion (ROM) testing
Active range of motion testing procedures were performed today using the ZERO-NEUTRAL, GRAVITY-BASED SFTR (Sagittal Frontal Transverse Rotation) Method from the AMA Guidelines to the Evaluation of Permanent Impairment, Fifth Ed., 2001.

The individual test measurements and their calculated impairments are objective tests that objectively measure patient progress toward treatment goals and help determine when MMI is reached.

103

Final Re-exam
(Example of Documentation)

Objective:
Cervical range of motion was measured, and the following was found:

Flexion	(Normal 45 degrees):	was 40	now 45
Extension	(Normal 45 degrees):	was 18	now 45
Left Rotation	(Normal 80 degrees):	was 22+,	now 80
Right Rotation	(Normal 80 degrees):	was 26+,	now 80
Left Lateral Flexion	(Normal 45 degrees):	was 12+L	now 45
Right Lateral Flexion	(Normal 45 degrees)	was 10+	now 45

The above findings show full cervical ROA, and coupled with updated OA scores, indicate significant positive improvement since his last exam.

104

Final Re-exam
(Example of Documentation)

Objective:
Range of Motion Testing. Lumbar range of motion was measured and the following was found:
(+ = mild pain ++ = moderate pain +++ = severe pain)

Flexion	(Normal 90 degrees):	was 45+	now 90
Extension	(Normal 25 degrees):	was 10+	now 25
L. Rotation	(Normal 30 degrees):	was 20	now 30
R. Rotation	(Normal 30 degrees):	was 20	now 30
L. Lateral Flexion	(Normal 25 degrees):	was 10+	now 25
R. Lateral Flexion	(Normal 25 degrees):	was 10+	now 25

The above findings show full lumbar ROA and, coupled with updated OA scores, indicate significant positive improvement since his last exam.

105

Final Re-exam
(Example of Documentation)

Objective:

Kemp's Test was negative bilaterally.

The patient completed the following outcome assessment form and the results were compared to those completed during the initial exam to measure patient progress toward treatment goals and to help determine when MMI is reached.

Oswestry Disability Questionnaire functional outcome assessment tool with beginning score of 46%. The current overall score today is 0.

Neck Pain Disability Index Questionnaire functional outcome assessment tool with beginning score of 56%. The current overall score today is 0.

106

Final Re-exam
(Example of Documentation)

Objective:

Upon consideration of the information available, the diagnoses have changed to:

M99.02	Seg and somatic dysf of thoracic reg
M99.03	Seg and somatic dysf of lumbar reg
M99.01	Seg and somatic dysf of cervical reg
M48.14	Ankylosing hyperostosis [Forestier], thoracic region
M50.323	Other cervical disc degeneration at C6- C7 level

107

Final Re-exam
(Example of Documentation)

Assessment:

An initial detailed exam was performed on 05/16/21 and a follow-up re-exam was performed on 6/11/2021. Today, (07/15/21) a re-exam was performed.

The objective treatment goals and the patient's personal goals have been met.

Based on the subjective and objective exam findings from today's re-exam, no additional functional improvement is expected, and the patient has reached maximum medical improvement (MMI).

The patient's prognosis is good.

He will be adjusted today and released to maintenance care, and encouraged to continue his exercise program.

108

Final Re-exam
(Example of Documentation)

Time was the basis for E/M code selection for today's detailed exam (**99213**) and is based on a **total time spent today of 25 minutes.**

Face-to-face time:
15 minutes: a detailed reexam was performed today. Reviewed treatment goals with the patient, reviewed all objective exam findings with patient, explained objective tx goals had been met, as well as his personal goals. Reviewed exercises he must continue. Reiterated the importance of exercise and regular chiropractic maintenance care to maintain progress made and to prevent relapse, and made recommendations for regular monthly maintenance care visits.

Non-face-to-face time:
10 minutes: The patient met with office support staff for further questioning about patient's complaints and symptoms. Information obtained by staff, and patient intake questionnaires were reviewed an annotated by the examining provider. Ordered tests/studies and reviewed all clinical exam findings (subjective and objective). Completed documentation in health care record.

109

Final Re-exam
(Example of Documentation)

Treatment:
As part of his maintenance care, adjustments were delivered today in the following manner: Specific chiropractic spinal adjustments including the following techniques: Diversified technique and ProAdjustor were performed in 1-2 regions at the following spinal levels C1, C2, C3, C5, C6. C7, T1, T2, T3. T4, T5, T6, T7, T8 and L1.

The patient was advised to return in 1 month for maintenance care and was reminded of the importance of continuing his weekly exercise.

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Reminder:
Time as Basis for Code Selection

Use **total time**
(on the day of the encounter)
as the **basis for code selection** to be more appropriately paid for the work and time spent providing EM services!

111

Let's Dig in….

HNS Best Practices:

Philosophy of Care
&
Clinical Quality and Documentation Standards

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HNS Philosophy of Care

A core HNS tenet is that physicians should be able to make treatment decisions based upon their own clinical judgements.

With this tenet at its core, HNS has adopted a philosophy of care as a framework for providing safe, effective and cost-efficient healthcare.

This ***Philosophy of Care*** has been approved and adopted by the HNS Professional Affairs Advisory Boards.

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HNS Philosophy of Care

Treat and Release:
Provide care to correct the presenting condition, bring the patient to maximum medical improvement, and discharge the patient from active care with appropriate instructions regarding maintenance/supportive care, self-care, and prevention of future occurrences.

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HNS Best Practices

Clinical Quality
&
Documentation Standards

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HNS Best Practices
Clinical Quality & Documentation Standards

These ***Best Practices***
support the **triple aim of healthcare**
and represent HNS' performance expectations for
Network Physicians.

HNS' Best Practices are available on the HNS Website under the section titled '**Clinical Resources**'.

Unless otherwise indicated in this presentation, the clinical and documentation standards referenced in this program are HNS Standards and should not be confused with standards or guides issued by licensing boards or the ACA.

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HNS Best Practices

In addition to these Best Practices,
with assistance and support of HNS Professional Affairs Advisory Boards (PAAB), HNS has also developed
***Best Practices* –Acute Low Back Pain, Cervical Pain, Thoracic Pain, and Headaches.**

These Best Practices establish HNS performance expectations regarding treatment provided to adults with acute low back pain. These Best Practices are available on the HNS Website under the section titled 'Clinical Resources'.

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Important Terms / Definitions

Before we move forward,
let's review some important terms…

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Medical Necessity

The NC Dept of Insurance defines Medical Necessity as follows:

"Medically Necessary" means those Covered Services or supplies that are:

- (1) provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes;
- (2) necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms;
- (3) within generally accepted standards of medical care in the community; and (4) not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered."

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Medical Necessity

As a general rule, insurance plans only cover medically necessary chiropractic care, as defined in their **Corporate Medical Policy (CMP).**

As physicians representing certain health care plans, we are required to understand and comply with their CMPs, **including how they define "medically necessary" care**.

It is important to remember that not all "clinically appropriate" care meets the payor requirements for "medically necessary" care.

(Payor CMPs are posted on the HNS Website in the HNS/Payor Policies section.)

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Medical Necessity
Notes from CIGNA CMP

CIGNA CMP, in part, states it "covers chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) **as medically necessary** when ALL of the following conditions are met:

- A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function."

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Medical Necessity
Notes from CIGNA CMP

CIGNA CMP cont.

- "The individual is involved in a treatment program that clearly documents all of the following:
  - a prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time
  - the symptoms being treated
  - diagnostic procedures and results
  - individualized treatment plan with identification of treatment goals, frequency and duration
  - demonstrated progress toward significant functional gains and/or improved activity tolerances."

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Maintenance Care

Maintenance Care is elective healthcare that is typically long-term and provided at regular intervals to improve good health, prevent disease and spinal degeneration, prolong life, and enhance the quality of life.

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

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Supportive Care

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

Supportive care follows appropriate application of active and passive care including rehabilitation and/or lifestyle modifications. Supportive care is appropriate when alternative care options, including home-based self-care or referral, have been considered and/or attempted." (*American Chiropractic Association*)

Most health plans do NOT cover supportive care.

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Maximum Medical Improvement (MMI)

Maximum Medical Improvement

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

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HNS Best Practices

The Healthcare Record

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The Healthcare Record

As the legal document substantiating healthcare services provided to the patient, the healthcare record serves as a method of communication among healthcare providers caring for a patient and provides supporting documentation for reimbursement sought for services provided to a patient.

A healthcare record must be created
for each patient who receives care at the provider's practice,
(and maintained per legal requirements)
whether care was provided by the physician or
his/her support staff.

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Documentation in the Healthcare Record

Excellent clinical care
should be evidenced through excellent documentation in the clinical record.

Excellent documentation
supports clinical decision-making, treatment strategy, and the medical necessity of treatment provided

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Documentation in the Healthcare Record

Revise your view of documentation
from a necessary chore
to an opportunity to clearly establish
the excellent care you provide.

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Documentation in the Healthcare Record

Thorough, precise, and timely documentation of services provided is in the best interests of each healthcare provider, his/her patients, and of the payors responsible for the payment of those services.

The following are
basic standards for documentation
regarding healthcare records and are consistent with industry standards.

These standards are in addition to documentation standards noted elsewhere in this training module.

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Documentation in the Healthcare Record

- ✓ Contents of records will be organized in date-order; entries will be added chronologically.
- ✓ Each page of the healthcare record will include the signature (or electronic equivalent) of the rendering provider, including the professional designation "DC". If entries are made on the same page by more than one provider, the author of each entry must be identified.
- ✓ Entries into the record will be contemporaneous with the encounter.
- ✓ Each entry in the record will be dated with day, month, and year.
- ✓ No entries should be erased, deleted, or "whited-out". Corrections or changes shall be made by marking a single line through the original entry. Both the entry that is marked through and the corrected entry will be dated and initialed.

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Documentation in the Healthcare Record

- ✓ Primary language and/or linguistic service needs from patients with limited English proficiency, or patients with disabilities requiring special assistance, should be prominently noted in the healthcare record.
- ✓ If abbreviations are utilized, only standard abbreviations common to all healthcare providers should be used.
- ✓ Abbreviations in the healthcare record should be legible. An abbreviation key (or legend) should be maintained in the physician's office and produced in response to requests for healthcare records from HNS, contracted payors, and/or regulatory bodies.

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Documentation in the Healthcare Record

- ✓ The healthcare record should include all relevant information regarding patient non-compliance.
- ✓ The healthcare record should reflect any missed or canceled appointments.
- ✓ The healthcare record will include all correspondence and evidence of all communication to/from other sources regarding the patient, the rationale for any referrals to other providers, and all communications to/from the provider to whom the patient was referred.
- ✓ The healthcare record will clearly indicate any requests for consultations and copies of all written reports back to the healthcare provider who requested the consultation.
- ✓ The healthcare record will support the appropriateness of each CPT/HCPCS/ICD code reported on insurance claims.

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Documentation in the Healthcare Record (Imaging Studies Taken Elsewhere)

If the patient brings (or provides) past healthcare records, including but not limited to, results of imaging studies, copies of these should be added to the patient's permanent healthcare record. Further, the healthcare record MUST include:

A summary of all relevant information obtained from the review of the records/studies, and this summary must be **signed by the chiropractor** who reviewed them.

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Confidentiality Healthcare Records

All providers have legal, professional, and ethical obligations to protect patient confidentiality, and Protected Health Information (PHI), which includes information in the healthcare record. (HNS Compliance Policies for Contracted Health Care Professionals include policies relating to HIPAA/HITECH. Those policies are posted under the "Compliance" section of the HNS Website.)

It is essential that the confidentiality of the information in the healthcare record be safeguarded and shared only as necessary to protect the interests of the patient.

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Confidentiality Healthcare Records

Physicians shall:

- ✓ Ensure the privacy and security of the patient's healthcare information in a manner consistent with state and federal laws.
- ✓ Develop and implement practices that protect confidentiality of information and data.
- ✓ Ensure that healthcare records are stored and archived in a secure environment.
- ✓ Ensure that those accessing (or seeking to access) healthcare records have the authority to access it.

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Confidentiality Healthcare Records

Unless otherwise required by law, ensure that patient-specific health information is only released to:

- The individual to whom the information relates.
- HNS or a healthcare plan contracted with the physician to perform healthcare delivery, payment, administration, and/or management functions on their behalf.
- A third-party only if specific authorization is obtained from the individual to whom the information relates.

Except as otherwise provided by law, physicians will make member's patient-specific health information available to the member for inspection or copying.

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Retention Healthcare Records

Healthcare records must be organized and stored in a manner that allows for immediate access and easy retrieval.

Healthcare records shall be stored in a secure manner that allows access only by authorized personnel.

Complete patient healthcare records (including billing and payment information, such as EOBs) must be maintained for a **minimum of 10 years** from the last date of service OR, if the patient is a minor, for 10 years after the minor patient reaches age 19. Once the patient reaches 19 and is still under care, the physician should retain the patient healthcare record for 10 years from the last date of service.

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Back-up Recovery Procedures

Because of HIEA (HealthConnex), the use of electronic health records (EHR) and electronic documentation software programs are required for NC Chiropractors who are part of the HNS Network.

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

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

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HNS Best Practices

Chief Complaint & History

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Chief Complaint

A chief complaint is a statement which describes the symptom, problem, and/or condition that is the reason for the encounter.

Documentation: The patient's healthcare record should include the patient's chief complaint, with reference to:

- ✓ Mechanism of trauma
- ✓ Onset, duration, frequency, location and radiation of symptoms.
- ✓ Aggravating or relieving factors.
- ✓ Causation, accident, injury, or other etiology.

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History

A carefully obtained history yields critical information in the assessment. In addition to onset/duration/site and radiation of pain, history should include:

- Precipitating and relieving factors.
- Severity and functional impact.
- Neurological deficits.
- Symptoms of systemic illness.
- Current and past health conditions, including previous injuries.
- Past medical history, family medical history and social history.
- Current and relevant past medications (both Rx, OTC).
- Past/present treatment for the presenting condition and results of treatment.
- Previous relevant imaging studies (or other diagnostic testing).
- All health risk factors.

Documentation must include evidence of all of the above.

142

History

Red Flags
A focused history taking is the most critical tool for identifying risk factors for serious disease (red flags). "Red flags" are the current clinical features and prior illnesses that warn of a possible specific cause which may lead to serious problems unless it is treated immediately.

At each visit, Network Physicians should evaluate for the presence or absence of red flags. Identification of a red flag warrants close attention, and suggests the need for further investigation and possible specialist referral as part of overall treatment strategy.

While positive red flags are typically indications for imaging, red flags should be evaluated in the context of the clinical presentation as a whole.

143

History

Yellow Flags
While the presence of red flags indicates the potential for serious life or limb threatening pathology, psychosocial risk factors (yellow flags) include the patient's attitudes and beliefs, emotions, behaviors, and family and workplace factors.

As with red flags, Network Physicians should evaluate yellow flags in the context of the clinical presentation as a whole.

144

History

During the history,
obtain the name of the patient's primary care provider and/or medical specialist, and permission to contact in order to facilitate coordination of care.

145

HNS Best Practices

Initial Exam

146

Initial Exam

The **physical examination** should include:

- Vitals (at a minimum, weight, pulse and blood pressure).
- Observations (e.g., patient's posture, gait, demeanor, pain behavior).
- Examination for presenting symptoms, including examination of area involved in chief complaint.
- Palpation, including structural abnormalities, tenderness, muscle spasticity, etc.
- Consideration of imaging studies and other diagnostic tests.

147

Initial Exam
Outcome Assessments

The physical examination should include:

- Appropriate chiropractic tests including Range of Motion (**reported in degrees**) and orthopedic and neurological tests as necessary to establish the extent and severity of the injury or condition; and to allow the physician to establish objective, measurable *and reasonable* treatment goals.
- The initial examination must include **Outcome Assessments** to establish a **functional baseline**

148

Initial Exam
Outcome Assessments

Outcome Assessments
support clinical decision-making, treatment strategy, and help to establish the medical necessity of treatment.

Outcome Assessments
are required on the *initial exam* to establish a **functional baseline.**

Outcome Assessments
during the *initial* exam are **essential for *establishing 'measurable' treatment goals,***
(and during re-exams to objectively evaluate effectiveness of treatment and patient progress toward tx goals.)

149

Outcome Assessment Forms

The following OA forms are available on the HNS website and are also available in Spanish.

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

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

150

Initial Exam
X-rays

Clinical decision-making regarding the appropriateness of all diagnostic testing (particularly x-rays) should be determined by the physician in light of the clinical data presented by the patient, the diagnostic and treatment options available, and the patient's preferences and values.

151

Initial Exam
X-rays

Initial and subsequent x-rays must be medically necessary, and consistent with the patient's complaint, clinical findings, diagnoses and treatment plan.

152

BCBSNC Reimbursement Policy
X-rays & Low Back Pain

Effective June 18, 2023, BCBSNC has a new reimbursement policy regarding imaging studies on patients with low back pain. *This policy applies to ALL healthcare providers,* and in sum, states:

Regardless of the patient's age,
unless the patient presents with certain "red flags" or *has uncomplicated low back pain lasting more than 28 days,*
imaging services (X-ray, CT scan, or MRI) billed within 28 days of a principal diagnosis of uncomplicated LBP
are not eligible for reimbursement.

(**Note**: Per BCBSNC, the 28 days begins on the date of onset of low back pain and is not dependent on when the LBP dx was actually made.)

153

BCBS Reimbursement Policy X-rays (Low Back Pain)

Red Flags: If the patient presents with one of the following "red flags", imaging studies within the first 28 days of the low back pain diagnosis **ARE** considered clinically appropriate:

- Cancer
- Recent Trauma
- IV Drug Abuse
- Neurologic Impairment
- HIV
- Spinal Infection
- Major Organ Transplant
- Prolonged Use of Corticosteroids
- Osteoporosis
- Fragility Fracture
- Lumbar Surgery
- Spondylopathy
- Palliative Care
- Hospice
- Frailty ***and*** Advanced Illness (must have both; applies to patients 66 years of age and older)
- Malignant Neoplasm
- History of Malignant Neoplasm
- Other Neoplasms
- IV Drug Use

154

BCBS Reimbursement Policy X-rays (Low Back Pain)

If the patient presents with one or more requisite "red flags" *or has uncomplicated low back pain lasting more than 28 days*, imaging services may be performed without waiting the 28 days, but when billing for the imaging study, the service **must be appended with a KX modifier to indicate the presence of a "red flag" or to indicate that the low back pain has lasted more than 28 days.**

155

BCBS Reimbursement Policy X-rays (Low Back Pain)

Important Documentation Notes:

- If performing an imaging study on a patient with uncomplicated LBP lasting more than 28 days, you must (1) append the imaging CPT code with Modifier KX AND (2) *the healthcare record must clearly establish that the patient suffered from low back pain for more than 28 days prior to the imaging being performed*.
- If performing an imaging study on a patient with low back pain lasting less than 28 days based on a 'red flag', it is NOT necessary to report the "red flag" diagnosis on the claim form, but the healthcare record must include evidence of the 'red flag' diagnosis and the imaging CPT code must be appended with Modifier KX.

156

BCBS Reimbursement Policy X-rays (Low Back Pain)

Relevant to this new BCBSNC Policy, per BCBSNC, low back pain diagnoses include, but are not limited to, the diagnoses listed below:

- Low back pain
- Segmental and somatic dysfunction of lumbar region
- Segmental and somatic dysfunction of sacral region
- Radiculopathy, lumbar region
- Radiculopathy, lumbosacral region
- Lumbago with sciatica, left side
- Lumbago with sciatica, right side
- Intervertebral disc disorder with radiculopathy, lumbosacral region
- Other intervertebral disc displacement, lumbar region
- Other intervertebral disc degeneration, lumbar region
- Other intervertebral disc degeneration, lumbosacral region
- Spondylosis without myelopathy or radiculopathy, lumbar region
- Spondylosis without myelopathy or radiculopathy, lumbosacral region
- Sprain of ligaments of lumbar spine, initial encounter

157

BCBS Reimbursement Policy X-rays (Low Back Pain)

For the list of red flag diagnoses, please go to the ICD-10 section of the HNS Website and click on BCBSNC Reimbursement Policy – Imaging Low Back Pain

Lastly, this policy applies to any patient with BCBS insurance that presents to your office, including but not limited to:

- State Health Plan (SHP)
- Federal Employee Program (FEP)
- Self-funded plans (Administrative Services Only (ASO))
- Out of state BCBS plans (fully insured and Blue Card host claims)

158

BCBS Reimbursement Policy X-rays (Low Back Pain)

How to Get Reimbursed (Non-covered Service Waiver)

If you believe x-rays are clinically appropriate/medically necessary for your patient with LBP, but those x-rays are not eligible for reimbursement by BCBS because of the above policy, you may bill the patient directly for the needed x-rays, provided that you first obtain a signed non-covered service waiver from the patient in which he/she agrees to pay for the x-rays, **and provided the signed non-covered service waiver is on file in the patient's healthcare record.**

159

Subluxations Physical Exam

To report CMT to payors (including CMS), subluxations found during the exam must be demonstrated by one of two methods:

x-ray
or
physical examination.

160

Subluxations Physical Exam

X-ray:

The x-ray report indicating subluxation (**signed by the treating physician**) included in the health care record will serve as demonstration of the subluxation.

161

Subluxations Physical Exam

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

1. Pain/tenderness evaluated in terms of location, quality and intensity.
2. Asymmetry/misalignment identified on a sectional or segmental level.
3. Range of motion abnormalities (changes in active, passive, and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility).
4. Tissue changes in the characteristics of contiguous or associated soft tissues; including skin, fascia, muscle, and ligament.

162

Initial Exam Documentation

The clinical record must include:

- Written evidence of the results of the exam (including examination of area involved in the chief complaint).
- Evidence vitals were obtained (at a minimum, weight, pulse, and blood pressure).
- Evidence outcome assessments were utilized to establish a **functional baseline**.
- The specific tests/studies performed, as well as the results of each.

163

Initial Exam Documentation

The clinical record:

- Must indicate that all imaging ordered was consistent with the patient's chief complaint and clinical examination findings.
- As applicable, include the specific region(s) x-rayed and specific views taken (i.e., AP/Lateral, etc.), the name of the provider that reviewed the studies, date reviewed, and the interpretation of the study.
- Should the physician obtain the results of imaging studies or other diagnostic tests performed elsewhere, the healthcare record shall include clear evidence of the review of those studies by the treating physician, and a summary of findings.
- There should be documented evidence that clinical findings support the need for **repeat x-rays.**

164

Initial Exam Documentation

The clinical record must include:

- If subluxation was confirmed via x-ray, the healthcare record must include an x-ray report *signed by the physician* which establishes the subluxations.
- If subluxations were demonstrated by exam, documentation must support that 2 of the 4 required P.A.R.T criteria were met (pain, asymmetry, range of motion, tissues changes); one of which must be range of motion or asymmetry.
- ALL clinical examination findings **(objective and subjective).**
- Sufficient documentation to 1) support the basis of E/M code selection (time or medical decision-making) and 2) substantiate the specific level of E/M code reported.

165

Diagnoses

The history and examination provide the clinical rationale for appropriate diagnosis and subsequent treatment planning.

- Establish a diagnosis (or diagnoses) based on the history and clinical exam findings.
- The diagnosis or diagnostic impression must be reasonable based on the patient's chief complaint(s), results of clinical exam findings, diagnostic tests, and other available information.
- Diagnoses must clearly support the treatment outlined in the treatment plan.

166

Diagnoses Documentation

- The patient's healthcare record must reflect all diagnoses/clinical impressions that coexist at the time of the visit that require or affect patient care.
- The diagnoses in the healthcare record must be supported by documented objective clinical findings, diagnostic tests, etc.
- All services/DME documented in the healthcare record shall be supported by an appropriate diagnosis.
- Any changes in diagnoses must be documented in the healthcare record.

167

Diagnoses (ICD-10 Codes)

- ✓ Always code *to the highest level of specificity*!
- ✓ Code to the level of *certainty known for that encounter.*
- ✓ Codes that describe symptoms and signs are acceptable ONLY *if they represent the highest level of diagnostic certainty documented by the doctor.*
- ✓ Code all documented conditions that coexist at the time of the visit that require or affect patient care.
- ✓ Remove codes for conditions that no longer exist.

168

Assessment

A thorough assessment
is essential in order to determine the
appropriate pathway of care for each patient.

The history and examination
provide the clinical rationale for appropriate
diagnosis and should determine the appropriate
treatment strategy.

169

Assessment

The assessment should include, but is not limited to, the following:

- Review of the patient's chief complaint.
- History (presence of red and/or yellow flags).
- Functional Deficit Measurement.
- Examination.
- Imaging and other diagnostic testing (as applicable).
- Diagnoses and prognosis.
- Obstacles to recovery and strategies to overcome, if applicable.
- Consideration of coordination of care/referrals.

170

Assessment Documentation

- The healthcare record must include the physician's assessment of the patient and the patient's condition.
- The assessment must be consistent with the history, chief complaint, and objective examination findings, and the treatment strategy.

171

The Clinical Exam
The Bottom Line

For covered services provided and billed to payors, **clinical examination findings**:

- Must be consistent with the patient's chief complaint, diagnoses and treatment plan.
- Must *objectively* substantiate the medical necessity of the services provided.

Medical Necessity
requires
***documented objective* clinical findings.**

172

HNS Best Practices

Coordination of Care/Referrals

173

Coordination of Care/Referrals

Both initially and throughout care, providers should consider coordination of care and/or referrals.

Primary Care
Coordination of care with primary care providers and/or medical specialists should be considered.

Specialty Care
Specialty referral should be considered for potential surgical candidates, those for whom the diagnosis is uncertain, or those unresponsive to treatment.

174

Coordination of Care/Referrals Documentation

As applicable, the healthcare record should include evidence of continuity and coordination of care.

The health care record must include any recommendations to the patient to see his/her PCP, the basis for the recommendation, and evidence of any coordination of care, including but not limited to, any referrals to/from other health care providers.

All communications (written, telephone, etc.) to and from other health care professionals must be included in the clinical record.

175

HNS Best Practices

Treatment Plan

176

Treatment Plan

Once a diagnosis has been established based on the history and clinical exam findings, a treatment plan must be established for each patient.

177

Treatment Plan

Unless the care is maintenance/supportive care, a treatment plan shall be developed *for each episode of care.*

Each treatment plan
should be ***individualized***
and
specific to each patient's presenting complaints.

178

Treatment Plan (Goals)

In addition to relieving pain, the goal of treatment must be to
improve a functional deficit
related to the patient's present condition.

Treatment goals
should address specific ADLs
the patient is unable to perform.

179

Treatment Plan (Goals)

Treatment goals
must be
objective, measurable and reasonable.

180

"Objective & Measurable"

Objective

Fact-based; observable.

Measurable

Goals must be measurable so that we can objectively determine:

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

181

"Objective & Measurable" (Outcome Assessments)

Measurable

As previously noted, OAs must be utilized on the initial examination to establish a functional baseline.

OAs during the initial exam
are essential for
establishing 'measurable' treatment goals.

182

"Objective & Measurable"

Never use arrows!

Use percentages for ROM
and
Use actual numbers for other goals.

183

"Reasonable"

Reasonable
Must be reasonable in light of all clinical findings.

Must consider chronic conditions as well as certain structural conditions.

(What was the patient's pre-injury status????)
Let's say we have a patient with low back pain, with limited range of motion and severe spondylosis.

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

184

Treatment Plan (Visits)

Each treatment plan shall include anticipated duration of treatment, including frequency of visits.

Importantly
The *initial* treatment plan
should not exceed 4 weeks or 12 visits,
but may be modified at the first re-evaluation should the objective data from the re-eval indicate the appropriateness of additional care.

185

Treatment Plan

- Each treatment plan shall include all recommended treatment, including but not limited to, manipulations, modalities/therapies, DME, home instructions, *and the rationale for each.*
- ALL recommended services/DME included in the treatment plan *must be consistent with the chief complaint, clinical findings, and diagnoses.*
- For all therapies/modalities recommended, the plan must include ***the rationale for each***, including areas of application, frequency, duration, and if time-based therapy is planned, the length of time the service will be provided (i.e. 15 minutes).

186

Treatment Plan

- Each treatment plan shall include recommended activity modifications and home care instructions, as applicable.
- Treatment plans shall include expected outcomes.
- Treatment plans shall reference obstacles to recovery and strategies to overcome them.
- Treatment plans shall be modified in response to changes to the patient's condition.

187

Treatment Plan Documentation

The healthcare record must include documentation of ***ALL of the above.***

Additionally, documentation in the healthcare record must include:

- Any changes to a treatment plan and the rationale for those changes.
- Patient's progress as it relates to treatment goals.

(ALL subsequent visits should reference the patient's progress *as it relates to* **the *objective* goals of the treatment plans.**)

188

Education

Quality healthcare, in part, means engaging and involving the patient, so the patient takes ownership in preventive care and in the treatment of diagnosed conditions.

Patient education and managing the patient's expectations are an important part of the treatment of most chiropractic patients.

Successful treatment
depends on the patient's understanding of the condition and his/her role in recovery and in avoiding re-injury.

189

Education

Prior to initiating treatment, it is essential to provide the patient with clear, concise information regarding their condition, the treatment recommended, the anticipated length of treatment, the anticipated outcome, and his/her role in helping to achieve the desired outcome.

Additionally, information should be provided on the causes of pain, pain resolution, usual activity/work, prevention strategies, when to contact the chiropractor, and as applicable, when referral may be appropriate.

190

Education

At a minimum, education should include these points:

- Patients should take responsibility for, and actively participate in, the rehabilitation process.
- As applicable, stress the importance of staying active and continuing daily activities as normally as possible.
- Emphasize the importance of compliance to the treatment plan.
- Review what symptoms to watch for and when to contact the chiropractic physician.

191

Education

Successful patient education
increases patient satisfaction and results
in improved adherence to treatment and thus to
better outcomes.

192

HNS Best Practices

Informed Consent

193

Informed Consent

We are legally and ethically
obligated to obtain informed consent from our patients
prior to initiating treatment.

Informed consent is a process and consent cannot be considered "informed", ***unless at a minimum,*** the physician **orally explains the risks** associated with the proposed course of treatment, **answers any questions the patient may have,** and obtains the patient's permission to treat.

If the patient is a minor or an incompetent adult, the informed consent discussion must include the patient's parent or legal guardian.

194

Informed Consent

HNS strongly encourages the use of the *HNS Informed Consent form*, which can be found on the HNS Website, under HNS Forms.

If the HNS Informed Consent form is not used, a similar form that 1) specifically addresses the treatment to be provided, and 2) outlines the specific risks discussed with the patient must be used.

Written consent by a parent or legal guardian is required for minors or patients who are incapacitated. ***The form must be dated and signed by the parties and retained in the healthcare record.***

195

Informed Consent

Physicians shall obtain NEW informed consent when presented with a new condition that was not addressed *when the previous informed consent was obtained.*

(i.e. - lumbar manipulation conditions have a different group of risks of injury then that of cervical manipulation; a 70 year old may have different risk factors than a 20 year old; you are treating a low back condition and the patient develops a cervical complaint, etc.)

196

Informed Consent (Documentation Requirements)

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

The clinical record must include a signed and dated HNS Informed Consent Form (or other similar form which includes the treatment to be provided and the specific risks involved with that treatment).

197

HNS Best Practices

CMT

198

CMT

Most literature regarding spinal manipulation is based on high velocity, low-amplitude (HVLA) techniques and mobilization, such as flexion-distraction. Therefore, in the absence of contraindications, *these methods are generally recommended*. However, best practices for individualized patient care, based on clinical judgment and patient preference, may require alternative clinical strategies for which the evidence of effectiveness may be less robust.

The decision regarding the use of HVLA or instrument-adjusting should be based on clinical judgment, experience, and patient preference.

199

CMT Documentation

The clinical record will include:

- All manipulations performed.
- Specific segments and location of subluxations.

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

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

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

200

CMT Documentation

The clinical record will include:

- If subluxations were demonstrated by radiographs, there must be an appropriate x-ray report signed and dated by the physician.
- If demonstrated by physical examination, the record will establish that two of the four P.A.R.T. criteria are met (pain, asymmetry, range of motion, tissues changes); one of which must be range of motion or asymmetry.

201

HNS Best Practices

Therapies

202

Therapies/Modalities/DME

In conjunction with spinal manipulation, therapeutic modalities may provide therapeutic benefit and/or reduction in pain.

- During the initial phase of care, *no more than two therapies or modalities per visit* are considered usual or customary.
- There should be *a reduction in the number of therapies as the patient's condition improved*.
- As soon as clinically appropriate, consideration should be given to moving from passive therapies to active therapies to increase function and return the patient to regular activities.

203

Manual Therapy (97140)

Manual Therapy (97140) should be reported on the same day as chiropractic manipulation ONLY if the therapy is provided to an anatomical region different that the regions manipulated. Additionally, when reporting manual therapy on the same day as a manipulation, the diagnoses listed on the claim form must substantiate this, and the diagnosis pointer on the service line on the claim must first point to the diagnosis specific to the manual therapy.

If the manual therapy was performed on the *same anatomical region as the manipulation*, it should NOT be reported.

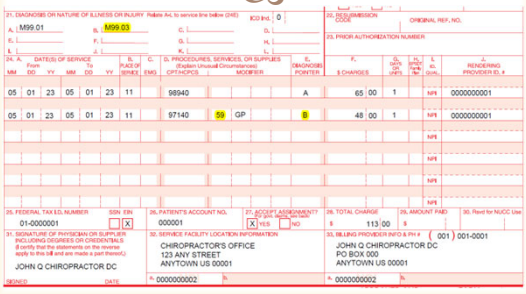
204

Manual Therapy (97140)

Importantly,
the **primary diagnosis**,
in the "**A**" position in box **24E** of the claim form
(diagnosis pointer)
that is linked to the manual
therapy code must clearly indicate the
manual therapy was performed to a
different anatomical region
than the region(s) manipulated.

205

Manual Therapy (97140)



206

Therapies/Modalities/DME Documentation

For therapies and modalities, documentation must include:

- Type
- Rationale
- Area of application (specific areas/regions involved in the therapy)
- Setting and frequency (as applicable)
- If the service is a time-based code, the actual time the service was performed.

207

HNS Best Practices

Re-examinations

208

Re-examinations

If the patient is still under care
after 4 weeks or 12 visits,
(whichever comes first)
a focused reevaluation must be performed.

As part of the reevaluation, and throughout the treatment, DCs must remain watchful for the appearance of **red flags**.

209

Re-examinations

At each re-exam, **outcome assessment tools must be utilized** (as well as other objective measures) in order to:

- Evaluate the effectiveness of treatment
- **Objectively measure progress towards treatment goals**
- Determine whether MMI has been reached and
- Determine the appropriateness of additional chiropractic treatment

210

Re-examinations

Reevaluation, at a minimum, should include the following:

- ✓ Vitals (weight, pulse and BP).
- ✓ Functional improvement assessed with appropriate OAs.
- ✓ Pain reassessed with a repeat VAS or other OAs.
- ✓ Function (ADLs) reassessed with OAs.
- ✓ As applicable, recommendations regarding modifications to activities/work.

211

Re-examinations

Reevaluation
must include an evaluation of treatment effectiveness and patient's progress *as it relates to treatment goals.*

The results of the reevaluation *should guide clinical decision-making regarding the next steps in care* and should be clearly explained to the patient.

212

Re-examinations Documentation

The clinical record will include:

- Evidence vitals were obtained (weight, pulse and BP).
- Evidence outcome assessments and other objective measures were utilized during the reexam.
- Evidence of a comparison of results of outcome assessments (and other measurable objective findings) to previously obtained data and **an evaluation of progress towards treatment goals**, the effectiveness of treatment, and, as applicable, the appropriateness of additional care.

213

Re-examinations Documentation

The clinical record will include:

- The specific tests performed and the results of those tests.
- ALL clinical examination findings **(objective and subjective).**
- Sufficient documentation to 1) support the basis of E/M code selection (time or medical decision-making) and 2) substantiate the specific level of E/M code reported.

214

HNS Best Practices

Subsequent Visits (Continuing Course of Treatment)

215

Course of Care (Subsequent Visits)

During each office visit, the physician should inquire as to the patient's presenting complaints, perform the treatment called for in the treatment plan, and, as applicable, monitor the patient's clinical picture through the use of objective tests such as range of motion, segmental range of motion, presence or absence of spasm or swelling, presence or absence of positive orthopedic findings, and pain assessment.

Throughout the treatment,
DCs must remain watchful for the appearance of **red flags**.

216

Course of Care (Subsequent Visits)

As the patient's condition improves, the *frequency of treatment should gradually decline* until the patient reaches the point of discharge.

217

Course of Care (Subsequent Visits)

If MMI is not reached during the initial course of care, and provided there is ***clear evidence that substantive, measurable function gain has occurred,*** a follow up course of treatment may be warranted. During this phase of care, generally speaking, patients should be encouraged to return to usual activity levels.

The decision regarding continued treatment, and the frequency of it, largely depends on the severity and duration of the condition and whether the patient has reached maximum medical improvement.

218

Course of Care (Subsequent Visits)

Additional chiropractic care may be indicated in cases of exacerbation or flare-up in patients who have previously reached MMI. However, the healthcare record must include information which clearly supports the basis and medical necessity for the additional care.

(i.e., Substantive, measurable prior functional gains with recurrence of functional deficits)

219

Course of Care (Subsequent Visits)

All covered services provided at each subsequent visit *(as well as the number and frequency of visits),* must be consistent with the patient's chief complaint, objective clinical findings, results of comparisons of tests and outcome assessments, diagnoses and treatment plan.

220

Subsequent Visits Documentation

For ALL subsequent visits, the health care record should include:

- **S.O.A.P**. notes.
- Any significant changes in subjective complaints, including but not limited to, frequency and intensity of pain or discomfort, and review of ADL deficits.
- Patient's response to treatment.
- All tests performed and the results of those tests.
- Any changes to the diagnosis.
- Changes to treatment and the rationale for the change.

221

Subsequent Visits Documentation

For ALL subsequent visits, the health care record should include:

- All services provided to the patient.
- Any patient education and/or home recommendations and/or any DME.
- As applicable, an evaluation of treatment effectiveness and patient's progress ***as it relates to treatment goals.***
- Evidence services provided are consistent with the patient's chief complaint, objective clinical findings, diagnoses and treatment plan.

222

Documentation (MMI and Discharge)

- The patient's healthcare record should clearly and objectively demonstrate **when maximum medical improvement has been reached**.
- The patient's healthcare record should include patient status on discharge, recommendations upon discharge, and prognosis.

223

HNS

'Core' Best Practices

224

HNS "Core" Best Practices

The following are considered essential "core" best practices intended to improve quality, treatment outcomes, and cost-efficiency.

- ✓ Establish and document the patient's chief complaint.
- ✓ Unless the care is maintenance or supportive care, develop an individual treatment plan for each patient.
- ✓ Based on the chief complaint and objective clinical exam findings, establish specific treatment goals for each patient which are *objective, measurable, reasonable, and intended to improve a functional deficit.*

225

HNS "Core" Best Practices

- ✓ Ensure the initial examination includes the use of standardized outcome assessment tools to establish a functional baseline *against which progress towards goals may be objectively measured.*
- ✓ Re-evaluate the patient every 4 weeks or 12 visits (whichever comes first). At each re-exam, use outcome assessment tools and other objective measures to measure progress toward treatment goals, the effectiveness of treatment, and the appropriateness of additional care.
- ✓ Use the comparison of the results of the outcome assessments and other measurable objective findings to determine when MMI has been reached, *then release the patient to maintenance/supportive care.*

226

HNS "Core" Best Practices

- ✓ Ensure all diagnoses, all services provided, the rationale for those services, and all treatment recommendations are properly documented in the healthcare record.
- ✓ With the exception of maintenance/supportive care, ensure that all treatment billed to payors is consistent with the chief complaint, objective clinical findings, diagnoses, payor corporate medical policies, and HNS Policies.

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HNS Best Practices

Detection & Prevention
of More Serious Health Issues

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Detection & Prevention of More Serious Health Issues

As Doctors of Chiropractic, we received extensive training in identifying conditions in patients, which enables us to recognize problems. Further, we see our patients on a more routine basis than most health care providers.

Chiropractors have the unique opportunity to consistently monitor their overall health and identify small changes that may be indicative of a larger issue. And of course, many conditions are far easier to treat when they are identified early.

A brief review….

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Detection & Prevention of More Serious Health Issues

As chiropractors, we know that cancer often gives no signs or symptoms that exclusively indicate the disease is present. Many complaints for cancer also can be explained by a relatively harmless condition. There are, however, **seven symptoms** that should elevate our suspicion of the possibility of cancer.

- Persistent cough over one month or blood-tinged saliva
- Blood in the stool or any change in bowel habits
- Unexplained weight loss, fever or night sweats
- Non-healing sores
- Change in urinary habits or blood in urine
- Obvious change in a wart or mole
- Persistent lumps, especially in the breasts or testicles

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Detection & Prevention of More Serious Health Issues

Most problems that present in chiropractic offices today are biomechanical in nature and do not necessarily signify a dangerous underlying abnormality. However, as we know, some pain indicates a serious condition, such as inflammatory disease, fracture, referred pain, infection, or cancer. To determine whether there is a potentially dangerous cause of pain, clinicians often seek historical or examination findings that might be "flags".

Red Flags and Yellow Flags

- **Red Flags** – a clinical symptom or sign that may indicate serious pathology as a source of the patient's spinal pain. This may represent a contraindication to treatment.
- **Yellow Flags** – a symptom or sign that should raise the index of suspicion regarding the development of chronicity in a patient with spinal pain.

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Detection & Prevention of More Serious Health Issues (Red Flags)

- Spinal pain of unknown origin in patient age <20 or >50
- Trauma related to pain
- History of cancer
- Night pain
- Fever, chills, night sweats, nausea, vomiting, fatigue, diarrhea
- Weight loss
- Pain at rest
- Corticosteroid use
- Recent infection
- Generalized systemic disease (diabetes)
- Failure of 4 weeks of conservative care
- Cauda Equina
- Saddle anesthesia
- Sphincter disturbance
- Motor weakness lower limbs

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Detection & Prevention of More Serious Health Issues (Yellow Flags)

- Superficial tenderness to light pinch
- Nonanatomic tenderness, which is not localized and often extends from the lumbar spine to thoracic or pelvis
- Axial loading pain, when low back pain is reported with vertical loading to the patient's head.
- Pain with whole body rotation, when shoulders and pelvis are rotated in the same plane.
- Discrepancy between seated and lying SLR
- Give-way or cogwheel weakness that cannot be explained on a localized neurologic basis
- Sensory disturbances in a stocking rather than a dermatomal pattern of distribution
- Disproportionate verbalization and facial expressions during examination

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Detection & Prevention of More Serious Health Issues (VAD)

NCMIC estimates the occurrence of "serious arterial syndromes" to be less than 1 in 2 million to 1 in 3.8 to 5.8 million cervical manipulations. *(NCMIC, Current concepts: Spinal Manipulation and Cervical Arterial Incidents, 2006)*

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Detection & Prevention of More Serious Health Issues (VAD)

The physician must be able to recognize the signs and symptoms of vertebral artery dissection (VAD).

The patient will characteristically complain, "I have pain in my head and/or neck unlike anything I have ever had before." This will not present as a typical headache. *If the patient presents with **an atypical headache**, the physician must first rule out a vertebral artery dissection.*

A review with the patient as to the signs and symptoms of a VAD must be documented.

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Detection & Prevention of More Serious Health Issues (VAD)

The "5 Ds and 3 Ns" are as follows:

- **D**izziness/vertigo/giddiness/light headed
- **D**rop attacks/loss of consciousness
- **D**iplopia (or other visual problems)
- **D**ysarthria (speech difficulties)
- **D**ysphagia
- **And = A**taxia of gait (walking difficulties), Ataxia of the extremities or falling to one side

- **N**ausea (with possible vomiting)
- **N**umbness on one side of the face and/or body
- **N**ystagmus

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HNS Best Practices

Patient Compliance

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Patient Non-Compliance

There is little doubt to any practicing physician that patient non-compliance is a significant and contributory factor to **poor outcomes.**

There is also little doubt that patient non-compliance can often lead to more aggressive and costly treatments.

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Patient Non-Compliance

It is important to recognize the difference between non-compliance and the patient's right to refuse care.

Patients have the right to make informed decisions regarding their care, including being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment.

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Patient Non-Compliance

Non-compliance may be the result of an educated, rational and reasonable decision on the patient's part to exercise control over their health care.

The medical record should include documentation that the diagnosis and proposed procedure/treatments were explained to the patient and that *the explanation included the patient's prognosis without the procedure, the risks and benefits, and alternative therapies.*

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Patient Non-Compliance

Best Practices to Enhance Patient Compliance:

- Emphasize the seriousness of any recommended imaging studies
- Explain the rationale for your treatment advice
- Allow the patient to voice any concerns they have about recommended treatments
- Attempt to gain agreement on the treatment plan
- Emphasize the importance of adhering to the treatment plan

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Patient Non-Compliance

Coordinate Treatment Plans with Other Providers Involved in Patient's Care.

Maintain good communication with other providers involved in the patient's care and maintain a clear understanding of the expectations and role in the patient's plan of care. Ask consultants to notify you if the patient fails to keep an appointment and request periodic updates on the care and treatment plan or a summary at the conclusion of care, whichever is appropriate.

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Patient Non-Compliance

Maintain a Reliable Tracking System

- Without a reliable tracking system, it may be difficult to identify patients who fail to keep scheduled appointments. If the patient refuses studies, recommended care, etc., **document it**!

(Failure to maintain a reliable tracking system is one of the most frequently cited problems in malpractice cases where there is an allegation of delay in diagnosis and/or failure to supervise care.)

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Patient Non-Compliance

Document Non-Compliance!

When the patient has failed to comply with your recommendations, document the non-compliance, avoiding any documentation that may look judgmental or self-serving.

Among the most common problem areas are:

- Repeated failure to keep appointments;
- Failure to have diagnostic studies or consultations with other health care professionals as recommended.

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Patient Non-Compliance

Document Non-Compliance!

HNS has created a **Patient Non-Compliance** form for this purpose.

The form is posted on the HNS website (HNS Forms).

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Chiropractic
Non-Compliance Form

Patient non-compliance is a significant and contributory factor to poor treatment outcomes which can lead to more costly health care as well as potential malpractice claims. Accordingly, it is the policy of this office to document non-compliance to treatment recommendations including but not limited to the frequency of treatment recommended in the patient's treatment plan.

Additionally, it is the policy of this office that services provided to patients who do not comply with this office's treatment plans/treatment recommendations will not be billed to their health care plans as such services are not consistent with "medically necessary care" and therefore, not covered by their health care plan. (This includes, but is not limited to, patients who do not keep scheduled appointments and/or choose to seek care at their discretion and/or at their convenience.)

.Patient: _____ **Date:** _____

Summary of Non-Compliance Issues
☐ Failed to adhere to treatment recommendations
☐ Failed to adhere to treatment schedule; repeatedly failed to keep appointments as outlined in treatment plan.
☐ Stopped care before treatment plan complete
☐ Other: _____

Follow-Up Actions Taken:
☐ Patient contacted and reminded of importance of complying with treatment recommendations and/or treatment/appt. schedule.

Method of Contact:
☐ Telephone ☐ Letter
☐ Email ☐ Fax
☐ Text

1. Initial Contact Attempt:_____
2. Subsequent Contact Attempts:_____

Final Action:
☐ Patient will be counseled on need for full compliance at next appt.
☐ Discharged patient (sent discharge letter)

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Summary

We hope this presentation and review of
HNS' Best Practices
will help improve quality of care, result in better treatment outcomes, improve the patient experience, and ensure documentation which supports treatment strategy and the medical necessity of care provided.

The *HNS Best Practices:*
Clinical Quality & Documentation Standards
are posted the HNS Website under the section titled '**Clinical Resources**'.

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Our Responsibility

We ALL have a responsibility to help make our healthcare system more efficient.

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The Time is Now

"*There is a professional and personal responsibility for each individual Chiropractor to take their patient care, documentation, and practice administration to a higher consciousness and level of competency.*"

"This 'cultural obligation' will either be determined by Chiropractors or by the payors."

"That cultural authority is now in our court but ultimately will not be, if we don't move forward quickly."

Dr. Kevin Sharp

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HNS

Together, we're making a difference.

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