Medicare Documentation

By

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Medicare Demonstration Project

- We are about to receive a 2% increase in our Medicare payments.
- This reflects the end of the Chiropractic Demonstration Project payback period.
- The Demonstration Project ran from 2005 to 2007.
- The purpose of the Demonstration Project was "for the purpose of evaluating the feasibility and advisability of covering chiropractic services under the Medicare program…"
- The law that enacted the Demonstration Project required that it be "budget neutral".
- That means that there could be no more money spent than would normally be spent on chiropractic care.
- The Demonstration Project went over budget by $50 million.
- This money has been recovered with a 2% reduction in Medicare payments to all chiropractors.

What Makes Good Documentation?

- Your records must be legible.
- All entries must be dated and signed by the doctor.
- If notes are handwritten, they must be in black or blue ink.
- Entries must be written or dictated within 24 hours of the patient encounter.
- There must be no erasures or white-outs on the records.
- There must be no blank spaces.
- The patient's name must be on each page or both sides of the page as applicable.
- Noncompliance, displeasure and negative events and reactions must be documented.
- Do not use different color pens on the same days notes.
- Recommendations for home care, exercises, and referrals must be documented.
- All recommended tests must have a report in the file.
- Only standard abbreviation should be used.
- Important: Never add or clarify an entry after you have received a subpoena for records!!
- All patient encounters should be recorded in the patient's file.
- This includes telephone calls and encounters with staff members as they relate to patient care.
- The "Absent-Minded Professor"
    - "I'm a good clinician but I am just not good with documentation."

- "OIG finds this statement neither charming nor acceptable." CMS Chief Medical Officer.

Required Documentation

- Initial Visit
  - History
  - Description of the present illness
  - Evaluation of musculoskeletal/nervous system through physical examination
  - Diagnosis
  - Treatment plan
  - Date of initial treatment
- Subsequent Visits
  - History
  - Physical Exam
  - Documentation of treatment given on day of visit

Initial Visit

History

- The history recorded in the patient record should include the following:
- Symptoms causing patient to seek treatment;
- Family history if relevant;
- Past health history (general health, prior illness, injuries or hospitalizations; medications; surgical history);
- Mechanism of trauma;
- Quality and character of symptoms/problem;
- Onset, duration, intensity, frequency, location and radiation of symptoms;
- Aggravating or relieving factors; and
- Prior interventions, treatments, medications, secondary complaints.
- Social History (not required but advisable)

Description of the Present Illness

- Mechanism of trauma;
- Quality and character of symptoms/problem;
- Onset, duration, intensity, frequency, location, and radiation of symptoms;
- Aggravating or relieving factors
- Prior interventions, treatments, medications,secondary complaints; and
- Symptoms causing patient to seek treatment.
- "These symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal), and joint (arthro) and be reported as pain (algia), Inflammation (itis), or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder, and hand problems as well as leg and foot pains and numbness."

- "Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such. The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited. A statement on the claim that there is "pain" is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined."

X-Rays

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

Evaluation of musculoskeletal/nervous system through physical examination

- Orthopedic Tests
- Neurological Tests
- Range of Motion Testing
- Muscle Strength Testing
- Palpation
- Outcome Assessments

Orthopedic Tests

- Use standard orthopedic tests for the area indicated
- Diagnosis should be consistent with test results

Neurological Tests

- Use standard neurological (reflexes and pin-prick sensitivity) tests for the area indicated
- Diagnosis should be consistent with test results
- The orthopedic tests, reflexes, and pin-prick sensitivity tests are primarily for the purpose of ruling out pathological processes.

Range of Motion Testing

- The gold standard as defined by the AMA is dual digital inclinometry
- You should document the measurement technique that you use

Muscle Strength Testing

- You can use either manual muscle testing or mechanically assisted muscle testing (such as Jtech)
- Document the method used
- The range-of-motion and muscle strength tests are primarily for functional assessment of the area of the spine tested and where changes in sectional mobility are noted for P.A.R.T.

P.A.R.T.

- P = Pain/tenderness evaluated in terms of location, quality, and intensity;
- A = Asymmetry/misalignment identified on a sectional or segmental level;
- R = Range of Motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility);
- T = Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle and ligament.
- To demonstrate a subluxation based on physical examination, two of the four criteria mentioned under "physical examination" are required, one of which must be asymmetry/misalignment or range of motion abnormality.
- A physical (palpitory) exam is used to evaluate the musculo-skeletal/nervous system to identify:
    - Pain/tenderness evaluated in terms of location, quality, and intensity;
    - Asymmetry/misalignment identified on a sectional or segmental level;
    - Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and
    - Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

Palpation

- Palpation is the manual inspection of the area of the spine indicated in the complaint.
- This is where the pain/tenderness, asymmetry/misalignment, changes in segmental mobility, and tissue, tone changes are noted for P.A.R.T.
- Muscular spasm A/T
- Muscle tenderness P/T
- Osseous malposition A
- Osseous tenderness P/T
- Motion, restricted R
- Motion, excessive R

Outcome Assessment Questionnaires

- "Questionnaires designed to measure a patient's limitations in performing the usual human tasks of living. Functional questionnaires seek to quantify

symptoms, function and behavior directly, rather than to infer them from less relevant physiological tests."

- Roland-Morris Questionnaire
- Revised Oswestry Low Back Pain Disability Questionnaire
- Neck Disability Questionnaire
- Other specialized questionnaires as indicated
    - Headache Disability Index
    - Dizziness Handicap Inventory
    - Shoulder Evaluation Form
    - Carpal Tunnel Questionnaire
    - Tinnitus Handicap Inventory

Subsequent Visit

Subsequent Visit History

- Review of chief complaint:
- Changes since last visit;
- System review if relevant

Subsequent Visit Physical Exam

- Exam of area of spine involved in diagnosis; (Palpation)
- Assessment of change in patient condition since last visit;
- Evaluation of treatment effectiveness.

Subsequent Visit Documentation of Treatment Given on Day of Visit

- Where did you adjust?
- How did you adjust?
- How did the patient respond to adjustment?

Subsequent Visit Notes

- The patient is improved HOW?
- The patient needs care WHY?
- The patient was adjusted WHERE?

S.O.A.P.

- S = History and chief complaint
- O = Exam and Outcome Assessment
- A = Assessment
    - This is where you get to be the doctor
    - Put your opinion here
- P = Plan
    - Treatment that was given and next appointment
- The SOAP Formula
- S + O = A which leads to P

- Subjective information plus Objective observations equal Assessment which is your opinion.
- You opinion leads to the development of your Plan
- The SOAP note was designed for the practice style of a MD
- We practice a little differently
- Assessment Visit
- Treatment Visit
- Assessment Visit
- The record requirements for the assessment visit would be the same as for a medical doctor; we note all subjective findings from the patient, we record all objective test results and observations, we assess the patient's condition and note it in the notes and diagnosis, and we formulate a plan of treatment with measurable goals.
- Treatment Visit
- The treatment visits are where we put the plan developed during the assessment visit into action.
- We would continue to note subjective statements from the patient regarding changes in their condition and objective findings from palpation.
- The assessment would be limited to determining if the patient is "on course" or not.
- During the treatment visit, the treatments and therapies administered to the patient and the patient's response to them should be noted.
- To develop an accurate picture of patient care another doctor or a reviewer would need a "block" of records including the records of the assessment visits before and after the date in question as well as all of the treatment visit records for the visits that occurred between those assessment visits.

Summary

- Medicare will pay for what is medically necessary.
- It is the responsibility of you, the doctor, to gather the required data and properly document the case to Medicare standards.
- This is how you keep the money that you have been paid**.**