Medicare Protocols and Procedures

By
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Intake (Initial Visit)

- At the initial visit you need to gather specific information in the history that Medicare requires.
- You need to inform the patient of what Medicare will cover and what the patient is financially responsible for.
- You need to perform an exam and, if indicated, x-rays.

Medicare requires the following at the initial visit

- History
- Description of the present illness
- Evaluation of musculoskeletal/nervous system through physical examination
- Diagnosis
- Treatment plan
- Date of initial treatment

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.

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.

Consultation

- Talk to the patient.
- Ask probing questions.

- Ask open-ended questions.
- Dig for secondary complaints.

Outcome Assessment Questionnaires

- You now know the area(s) of involvement.
- Administer the appropriate O.A.T.S. (Outcome Assessment Tools (or Tests))
- This measures the functional impairment of the patient.
- This gives you a baseline from which to measure progress.
- Medicare's definition of OATS
    - "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."Primary Outcome Assessment

  Questionnaires to use:
    - 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

ABN

- Administer the ABN here.
- Use the menu format in blank D and include all services that are statutorily excluded or might be denied.
- This is for your protection.

Evaluation of musculoskeletal/nervous system through physical examination

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

Diagnosis

- "The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named."

- Consult the LCD for your state.

Hierarchy of Diagnosis

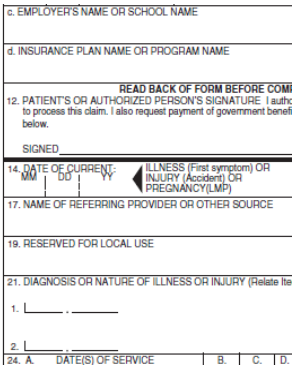
- Neurological Diagnosis
- 724.3 Sciatica
- Structural Descriptor Diagnosis
- 722.52 Degeneration of Lumbosacral Intervertebral Disc
- Functional Diagnosis
- 719.7 Difficulty Walking
- Soft Tissue, Extremity, Complicating Factors
- 847.0 Sprains and Strains of the Neck

Treatment Plan

- Recommended level of care (duration and frequency of visits);
- Specific treatment goals;
- Objective measures to evaluate treatment effectiveness.
- In other words:
- How long and how often are you going to see the patient
- What are you trying to accomplish
- How do you know when you have accomplished it

Date of Initial Treatment

- The Date of Initial Treatment in Box 14 of the CMS 1500 form is one of the key indicators of the need for a review.
- Generally if the date of initial treatment is more than three months old and the care is still being billed with the AT modifier then there is a good chance that the case will be reviewed.
- The Date of Initial Treatment goes in Box 14 of the CMS 1500 form.
- The date of initial treatment is:
- The date of the accident or
- The date of the first symptomChiropractors should put the date of the initiation of treatment.


c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

READ BACK OF FORM BEFORE COMI

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authc to process this claim. I also request payment of government benefi below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

19. RESERVED FOR LOCAL USE

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Ite

1. L_____ . _____

2. L_____ . _____

24. A. DATE(S) OF SERVICE | B. | C. | D.

- Do not put down a new initial treatment date unless there is a new condition or a recurrence of the current condition.
- To do so could be considered fraudulent.

Intake Summary

- You need to gather the information required by Medicare.
- You also need to gather enough data to establish the baseline functional condition of the patient.

- Without this information you will not be able to prove functional improvement and Medicare will deny the services as not medically necessary.
- Take the History
- Doctor consults with the patient
- Administer Outcome Assessment Questionnaires
- Deliver ABN
- Perform exams
- Take x-rays (if indicated)

Daily Visits (Subsequent Visits)

- The Daily Visits (or Subsequent Visits as Medicare calls them) have different, but very specific, documentation requirements.
- The protocols and procedures should cover these requirements.

Required Documentation

- History
- Physical Exam
- Documentation of treatment given on day of visit

Answer these questions:

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

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;
- Assessment of change in patient condition since last visit;
- Evaluation of treatment effectiveness.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.

P.A.R.T.

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

- Note the History
    - Review the chief complaint(s).
    - Check for significant changes in the condition or new complaints.
    - Review the pertinent systems if there are changes.
- Examine the patient
    - Palpate the area(s) of involvement and note the appropriate elements of PART.
    - Assess the objective changes since last visit.
    - Note if the patient is progressing as expected or not.
- Note the spinal areas that are adjusted.
- Continue the course of care described in the treatment plan until the re-exam.
- If the patient quits before the re-exam then note in their chart that the patient discontinued care against your advice.

Re-Exam

- Re-exams should be conducted every 30 days.
- Why?
- Because Medicare considers an Outcome Assessment to be current if it is 30 days or less old.
- The re-exam should be scheduled on a specific date in the treatment plan.At the re-exam you should:
    - Update the history.
    - Re-evaluate all positives and significant negatives from the initial examination.
    - Administer new Outcome Assessment Questionnaires.
    - Assess the effectiveness of the previous course of treatments.
    - Formulate a new treatment plan.
    - Modify the diagnoses as indicated.

- Performing regular re-exams is critical to monitoring the care of the patient.
- Third party payors, especially Medicare, need to see that you are responding to the changes in the patient's condition as they are treated and are not over treating.

Maintenance Care

- When the patient reaches Maximum Medical improvement they are given the option of continuing care and paying for it themselves or being placed on PRN care.
- There are specific steps that you must take when reporting this event to MedicareEvaluate the re-exam results before adjusting the patient.
- If the patient has reached Maximum Medical Improvement (no significant functional improvement between two consecutive re-exams), review the ABN with them and inform them that they will be financially responsible from this point on.File this claim by itself without the AT modifier and with the GA modifier.
- Medicare will deny this claim.
- All CMT services after this denial will be considered non-covered services.
- Per Medicare regulations, you are relieved from the limitations on charges that would apply if the services were covered.Carefully consider how you will handle charges after this point.
- If you are going to keep the charges at the Medicare rate then protect yourself by using a discount plan such as ChiroHealth USA.

Summary

- Medicare is detailed and complex.
- You must the gather the required data and phrase the documentation properly to prove medical necessity.
- Establishing protocols and procedures within your office to facilitate this will reduce the likelihood of denied claims.

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