

Treatment Plans

An Opportunity

- On Friday, July 19, published proposed changes to the 2014 Physician Fee Schedule.
- They included a request for comments on chiropractors being paid for E/M codes.
- In other words, being paid for exams.
- This will not happen fast.
- The comments will be evaluated during 2014 and any changes will happen in 2015 or later.
- This presents us with an opportunity.
- Dr. Evan Gwilliam and I are teaming up to research exactly what CMS is looking for and to develop an outline of how to present it in a concise and logical manner.
- As we develop this material we will send out updates.
- We have 60 days so we will not be dragging our feet on this.
- Watch for further updates.

S.O.A.P.

- We all know what S.O.A.P. is:
- S = Subjective (anything that the patient tells you)
- O = Objective (anything that you observe yourself)
- A = Assessment (your opinion regarding what the problem is)
- P = Plan (what you are going to do to fix the problem)
- This is well expressed as a formula:
- $S + O = A \rightarrow P$
- Soap was designed for the practice style of a medical doctor.
- The MD would use the subjective and objective findings to assess the patient's condition.
- He would then develop a plan that would involve either the patient self-administering the treatment (such as with a prescription) or going to a trained technician (such as a physical therapist).
- Many elements of our patient encounters are similar to what the MD does and some are different.

Assessment Visit/Treatment Visit Paradigm

- In chiropractic, we have two distinctly different types of patient encounters.
- The assessment visit.
- The treatment visit.
- Both are essential to properly care for the patient.
- Each has different documentation requirements.
- This is not a replacement of S.O.A.P. but a customization of S.O.A.P. to the particular practice style of chiropractic.

- The failure of third party payers and reviewers to understand this concept has led to unnecessary denials.
- I have been involved in situations where Medicare reviewers have demanded orthopedic and neurological exams at each visit.
- This makes as much sense as requiring a white cell count after each pill in a course of antibiotics.
- Keeping the assessment visits separate and distinct from the treatment visits helps both the patient and third party payers better understand what we are doing and why we are doing it.

Assessment Visits

- The initial patient encounter should be an assessment visit.
- The initial assessment visit is where we assess the patient's baseline condition and formulate a plan.
- We then use follow-up assessment visits 30 days apart to determine the effectiveness of treatment, the patient's improvement, and the need for additional treatment.
- We continue in this manner until the patient reaches maximum medical improvement.
- During the assessment visit we collect subjective information from the patient using the patient history form and consultation.
- We then conduct objective observations including:
 - Orthopedic and neurological tests to rule out pathological processes.
 - Functional outcome assessments to determine the functional ability of the patient.
 - Imaging studies if indicated.
- Using this information we assess the patient's condition and formulate appropriate diagnoses.
- This leads to the development of a plan of treatment (or treatment plan).
- This treatment plan is then implemented during the treatment visits.
- During the follow-up assessment visits we:
 - Obtain a history update to determine the patient's current condition.
 - Retest all positive and significantly negative tests from the orthopedic and neurological tests.
 - Re-administer the outcome assessment questionnaire.
- From this information we modify the treatment plan and diagnoses as indicated.

Treatment Visits

- The treatment visits implement the treatment plan developed during the assessment visit.
- We should continue to note the subjective statements from the patient regarding their condition.
- We should continue to make objective observations including using palpation to note the elements of P.A.R.T., proving the presence of sublaxation at that visit.
- The assessment is limited to determining if the patient is progressing as expected.
- We should note patient comments and changes in patient's conditions.

- The treatment visits comprise a 30 day segment of the total course of care.
- An assessment visit is conducted every 30 days to assess the patient's progress and determine if additional treatment visits are medically necessary.
- Once the patient reaches maximum medical improvement the course of care is finished.

Treatment Plans

- Treatment plans are required by Medicare.
- They are also sound medical procedure.
- They provide both you and the patient a roadmap of care.
- Almost all chiropractors produce a treatment plan.
- It is usually called a report of findings and usually only goes to the patient.
- We just do a terrible job of reporting the treatment plan to Medicare and the insurance companies.
- The following is from the 2009 OIG report.
 - “Documentation for treatment plans was insufficient”
 - “The medical reviewers indicated that treatment plans are an important element in determining whether the chiropractic treatment was active/corrective in achieving specified goals.”
 - “The goal may change throughout the treatment episode, but it should be documented in the medical record to demonstrate active/corrective treatment.”
 - “Of the 76 percent of records that reviewers indicated contained some form of treatment plan, 43 percent lacked treatment goals, 17 percent lacked objective measures, and 15 percent lacked the recommended level of care.”
- The lack of treatment plans is still a problem.
- In a May 29, 2012 release describing a new chiropractic service edit, Trailblazer listed examples of common billing errors.
- Those errors included:
 - “The Plan of Care (POC) and treatment record were incomplete or absent.”
 - “Lack of documented measurable goals and objective treatment effectiveness.”
- Medicare expects a treatment plan or “Plan of Care” for each patient for each course of care.
- Failure to have a treatment plan in the records will result in the claim being denied on review.
- Medicare has three specific elements that they require in each treatment plan.
- The treatment plan should include the following:
 - The level of care that is recommended (the duration and frequency of visits).
 - Specific goals that are to be achieved with treatment.
 - 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.

Recommended Level of Care

- Duration and frequency of visits.
- 3 times per week for 4 weeks.
- Set date for re-exam.
- The re-exam should be in 30 days regardless of how many visits there are.
- From Medicare Benefits Policy Manual, Chapter 15, Section 240:
 - “The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxation (e.g., sprains or strains) problems may require as many as three months of treatment but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.”
 - “Chronic spinal joint condition implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already “set” and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.”
- Medicare recognizes that an uncomplicated acute case may require three months of treatment and a chronic case may require longer.
- They also recognize that the early stages of treatment may be more frequent than the later stages.
- The somewhat “standard” three times per week for four weeks and then re-examine would fit within their parameters.
- Re-exams should be conducted every 30 days.
- The treatment plan should be re-evaluated at each re-exam and modified as necessary.
- The treatment frequency should be reduced unless there is a medically necessary reason not to.

Specific Treatment Goals

- Specific treatment goals
- Before you can establish goals you need to know what Medicare expects you to do for the patient.
- The Medicare Benefits Policy Manual, Chapter 15, Section 240.1.3 states:
 - “The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient’s condition and provide reasonable expectation of recovery or **improvement of function.**”(emphasis added)
- Clearly, Medicare expects that your treatment will result in some improvement of the patients’ ability to function, if not in a complete recovery.
- The current best measure of functional improvement is Outcomes Assessment Questionnaires. (Now referred to as OATS)

- The three most commonly used OATS by chiropractors are:
 - Roland-Morris Questionnaire
 - Revised Oswestry Low Back Pain Disability Questionnaire
 - Neck Disability Questionnaire
- The specific treatment goals should include both short-term and long-term goals.
- The short-term goal would be to get the patient past their current level of impairment.
- The long-term goal would be to get the patient to the level of no impairment.
- Sometimes you reach the long-term goal and sometimes you don't.
- Note it in the chart either way.
- For example, if a patient should choose the selection from the Revised Oswestry Low Back Pain Disability Questionnaire that states: **“I cannot stand for longer than 1/2 hour without increasing pain.”**
- Based on the example above, an appropriate short-term treatment goal would be:
 - To enable the patient to stand for more than ½ hour without increasing the pain by re-exam
- An example of appropriate long-term Treatment goal would be:
 - To enable the patient to stand for as long as they want without pain.
- When you perform the re-exam you should change the treatment goals as appropriate.
- You need to document changes in the patient's condition and demonstrate that you are responsive to those changes.
- If, at the re-exam, a patient should choose the selection from the Revised Oswestry Low Back Pain Disability Questionnaire that states: **“I cannot stand for longer than 1 hour without increasing pain.”**
- The long-term goal would remain the same.
- The short-term goal would change to:
- Enable the patient to stand for more than one hour without increasing the pain.

Objective Measures to Evaluate Treatment Effectiveness

- This is determined using the outcome assessment questionnaire.
- In the above example the patient demonstrated improvement by simply selecting a different choice than they did on the initial questionnaire.
- Medicare Benefits Policy Manual, Chapter 15, Section 240.1.3(A) states:
- “When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.”
- You have to show clinical improvement from ongoing care or Medicare will consider the care maintenance and will deny coverage.
- Used properly, the OATS will prove functional (clinical) improvement and thus, will prove treatment effectiveness.
- Use the outcome assessment questionnaire at:
 - The initial exam
 - The half-way point of the initial Tx plan
 - The re-exam

- Each subsequent re-exam

Why Half-Way Point of Tx Plan?

- Mercy Conference Guidelines (page 124)
 - “**Acute Disorders:** After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered.”
- Using the OATS in this manner justifies four weeks of treatment when you do not have functional improvement at the first re-exam.
- When you have no functional improvement during the first phase of treatment and you have no other indication of improvement in the patient’s condition, then you need to seriously consider referring the patient to another doctor.

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.
- Generally, the date of initial treatment is:
 - The date of the accident or
 - The date of the first symptom
- Chiropractors are to use the date of initiation of the course of treatment as the initial date of treatment.
- The Date of Initial Treatment is important to Medicare.
- It enables them to determine how long the patient has been under care for a particular condition.
- Some reports have stated that more than 12 visits are unnecessary.
- Other reports have stated that any date in box 14 over 90 days old will trigger a review.
- Armed with this information, some doctors change the date of initial treatment every 10 visits or every 60 days.
- 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.