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Scott Munsterman, DC, FICC, CPCO
Brief Bio

Dr. Scott Munsterman is an acknowledged expert on the transforming model of health care delivery and compliance with a commitment to the promotion and advancement of the chiropractic profession. Dr. Munsterman is founder and CEO of Best Practices Academy, a clinical improvement organization providing focused leadership to bring practices into compliance with regulatory standards, equip them to improve clinical outcomes, and integrate into the transformed care delivery system. Dr. Scott works with ChiroArmor and eChiroEHR.

Dr. Munsterman is a graduate of Northwestern Health Sciences University, where he has served as Vice-Chair of the Board of Trustees and on the President's Cabinet as Chief of Care Delivery. He was awarded Chiropractor of the Year in South Dakota and the Fellow of the International College of Chiropractors (FICC). He is a professional compliance officer. Dr. Munsterman served two terms as Mayor of the City of Brookings and three consecutive terms in the South Dakota House of Representatives, where he chaired the House Health and Human Services Committee and also chaired the Legislative Planning Committee. He is author of the books "A Vision for South Dakota", "Care Delivery and Chiropractic: An Opportunity Waiting", and "Unfinished Business".

However, he states his greatest accomplishment has been his five daughters and six grandchildren - with more success to come.

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Disclaimer

The topics taught here are for the sole purpose of the chiropractic profession, any transference to other healthcare disciplines are at the risk of the individual's discretion. The presenter is an investor in the Best Practices Academy and ChiroArmor/ClinicArmor. The Best Practices Academy and ChiroArmor/ClinicArmor denies responsibility or liability for any erroneous opinions, analysis, and coding misunderstandings on behalf of individuals undergoing this course.

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference. We have based the majority of this program on the guidelines set forth by the OSHA, OCR, HHS, CMS, NCQA, URAC, AAAHC, AHRQ, and other agencies involved in health care standards and research dissemination, as it relates to the chiropractic profession. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

No legal advice is given in this program, and we encourage you to refer any such questions to your healthcare attorney.

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Documentation Overview

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Why is Quality Documentation of my Patient Records important?

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Reasons:

1. Reimbursement without Recoupment
2. Avoidance of filing False Claims
3. Validation of Performance to Standard of Care
4. Assure Patient Safety

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OIG Work Plan and Documentation Requirements

Understanding how the oversight of the Office of Inspector General impacts your risk for claims audits and recoupment of payments.

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U.S. Department of Health & Human Services

2021 Medicare Fee-for-Service Supplemental Improper Payment Data

Summary of High Level Findings

This document supplements improper payment information in the annual Department of Health & Human Services Agency Financial Report (HHS AFR). The Payment Integrity Information Act of 2019 (PIIA) requires improper payment reporting in the HHS AFR. The improper payment rate calculation complies with the requirements of Office of Management and Budget (OMB) Circular A-123, Appendix C. The Centers for Medicare & Medicaid Services (CMS) measures the Medicare Fee-for-Service (FFS) improper payment rate through the Comprehensive Error Rate Testing (CERT) program.

93.74 Percent Accuracy Rate and 6.26 Percent Improper Payment Rate[1,2,3]

Figure 1: Payment Accuracy (in Billions)

Common Causes of Improper Payments

Figure 2: Improper Payment Rate Error Categories by Percentage of 2021 National Improper Payments[4]

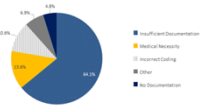
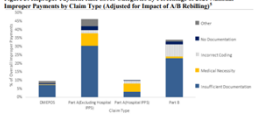


Figure 3: Improper Payment Rate Error Categories by Percentage of 2021 National Improper Payments by Claim Type (Adjusted for Impact of A/B Rebilling)[5]



https://www.cms.gov/files/document/2021-medicare-fee-service-supplemental-improper-payment-data.pdf-0

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Chiropractic: 2nd Highest Error Rate

Appendix J: Improper Payment Rates and Type of Error by Provider Type for Each Claim Type

Table J1: Improper Payment Rates by Provider Type and Type of Error: Part B

Provider Types Billing in Part B	Improper Payment Rate	Claims Reviewed	Percentage of Provider Type Improper Payments by Type of Error				
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other
Portable X-Ray Supplier (Billing Independently)	35.8%	99	0.0%	100.0%	0.0%	0.0%	0.0%
Chiropractic	33.7%	196	1.9%	80.8%	8.6%	2.7%	0.0%
Clinical Laboratory (Billing Independently)	23.7%	1,621	0.3%	90.0%	8.0%	0.2%	1.3%
HITT	22.1%	370	0.1%	97.3%	0.0%	0.0%	2.6%
Clinical Psychologist	16.8%	130	0.0%	99.9%	0.0%	0.1%	0.0%
Psychiatry	16.3%	97	1.9%	39.0%	0.0%	35.7%	23.4%
Physical Therapist in Private Practice	15.5%	442	2.4%	89.5%	0.0%	2.0%	6.0%
Endocrinology	13.6%	65	0.0%	64.5%	0.0%	24.8%	10.7%
Clinical Social Worker	13.5%	145	6.5%	90.0%	0.0%	0.0%	3.5%
Infectious Disease	13.3%	85	9.3%	32.4%	0.0%	47.6%	10.7%
Physical Medicine and Rehabilitation	13.1%	132	14.2%	61.4%	0.0%	24.4%	0.0%
Hospitalist	13.1%	199	4.5%	51.9%	0.0%	43.6%	0.0%
Interventional Cardiology	13.1%	153	0.0%	93.4%	0.0%	5.7%	0.9%
Radiation Oncology	12.7%	60	0.0%	99.4%	0.0%	0.6%	0.0%
Family Practice	12.2%	627	9.6%	58.6%	0.0%	22.5%	9.3%
Critical Care (Intensivists)	12.1%	46	69.1%	4.1%	0.0%	26.8%	0.0%
Podiatry	10.8%	221	3.1%	90.0%	0.0%	5.3%	1.6%
Internal Medicine	10.7%	1,192	6.9%	54.4%	0.0%	37.6%	1.1%
Ambulatory Surgical Center	9.9%	166	1.4%	95.5%	0.0%	0.0%	3.0%
Otolaryngology	9.8%	59	0.0%	57.0%	0.0%	43.0%	0.0%
Occupational Therapist in Private Practice	9.8%	48	0.0%	86.0%	0.0%	2.7%	11.3%
Anesthesiology	9.7%	184	3.0%	94.7%	0.0%	2.3%	0.0%
Nephrology	9.2%	192	9.3%	44.1%	0.0%	46.7%	0.0%
Pulmonary Disease	9.0%	157	0.0%	22.0%	0.0%	69.4%	8.7%
Gastroenterology	8.9%	207	3.8%	75.7%	0.0%	20.5%	0.0%
Emergency Medicine	8.7%	376	5.9%	20.3%	0.5%	62.0%	11.3%
Neurology	8.2%	176	31.5%	35.6%	1.3%	29.6%	0.0%

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Audits of chiropractic services… identified hundreds of millions of dollars in overpayments.

"Despite these findings, CMS has not implemented or effectively implemented all of our recommendations, and controls over chiropractic services remain inadequate to prevent fraud, waste, and abuse. "

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Overview of Medicare Program Vulnerabilities

"…the need for **better controls** over those services to protect the Medicare Trust Funds, **help reduce the risk of fraud**, and prevent beneficiaries from paying millions of dollars in coinsurance for chiropractic services that are not reasonable or necessary.

Further, chiropractic services that are not reasonable or necessary can **potentially harm** Medicare beneficiaries."

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OIG Recommendations to CMS

CMS should:

1) work with its contractors to educate chiropractors on the training materials that are available to them;
2) educate beneficiaries on the types of chiropractic services that are covered by Medicare, inform them that massage and acupuncture services are not covered by Medicare, and encourage them to report to CMS chiropractors who are providing non-Medicare-covered services;
3) identify chiropractors with aberrant billing patterns or high service-denial rates, **select a statistically valid random sample of services** provided by each chiropractor identified, review the medical records for the sampled services, estimate the amount overpaid to each chiropractor, and **request that the chiropractors refund the amounts overpaid** by Medicare; and
4) establish a threshold for the number of chiropractic services beyond which medical review would be required for additional services.

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Jurisprudence Review

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https://www.menti.com/al279xf862ga

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How to Achieve Influence in Public Policy

Former Representative Scott Munsterman

State of South Dakota

Served as:

Chair House Health and Human Services Committee

Chair Legislative Planning Committee

Majority Whip Leader

Mayor, City of Brookings, SD

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Key Aspects

1. General Legislative Process
2. Legislator relationships
3. Getting DCs into public office
4. Know your strategic plan for your state – Scope of Practice
5. Involvement

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General Legislative Process

Three Branches of Government

Executive, Legislative, Judicial

House of Representatives and Senate

(Bicameral Process - except Nebraska)

Federal versus State Law

State Law versus Administrative Rules

How a bill becomes a law

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Legislator Relationships: How do I approach this?

- It's all about TRUST
- Personal Contact
- Sweat Equity
- Communication
- Evidence-informed
- Know your "Talking Points"
- Credibility/Reputation

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Support DCs in their Campaigns for Public Office

- DCs make great public policy makers
- Influential within the community
- Active participation within community organizations
- Experience in serving in public office at the local level
- Evidence-informed as a clinician
- Heart of a servant

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Scope of Practice

Determined by your state legislation and administrative rules.

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What is your Professional Responsibility?

Understanding the responsibility within a professional standard of care pertaining to proper initial visit of the patient examination including medical decision-making process leading to a diagnosis and treatment plan for the patient. Documentation standards will be covered.

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Definition of Chiropractic

How does your state define chiropractic?

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Approved Practices and Procedures

What does your state law say about what practices and procedures are approved and considered safe for the public?

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Your documentation is the evidence of complying to expected standards of care of the profession and health care industry.

Clinical Standard of Care

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What is deemed as the Chiropractic Standard of Care?

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Chiropractic Standard of Care

- "What a (licensed) prudent, competent doctor of chiropractic in the same region would do in the same or similar circumstances."
- The chiropractic standard of care represents conduct that has been established with scientific, empirical, and/or clinical evidence.
- Consensus opinions including such factors as how widely used the form of treatment is, where it is taught, and how appropriate it is for the condition(s) upon which it is utilized are considered.
- Case law can be applied to help legally define specific aspects of the standard of care.
- Ideally, the standard of care represents the safest and most efficacious realm within which a chiropractor should conduct himself or herself professionally.

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Performance of a Standard of Care

Initial Visit:

- Properly evaluating the patient in a thorough manner to establish a viable working diagnosis, along with ruling in/out other possible diagnoses and their potential complications (i.e., differential diagnoses)
- Determine the safety and efficacy of any proposed course of treatment.
- Provide the patient with Informed consent through the appropriate process.

Subsequent Visit:

- Documenting patient encounters to demonstrate the authenticity of the patient encounter and patient's response to treatment.
- Re-evaluations are typically a required part of any prolonged course of treatment, or after a prolonged period of a patient's absence from care.

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Common Issues in a Breach of the Standard of Care

- Failure to keep quality records
- Altering patient records
- Informed Consent not provided correctly
- Adverse events from evaluation and/or treatment
  - Negative side-effects of treatment
  - Mis-diagnosis or failure to diagnose
  - Failure to refer

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How does a provider prove he or she has performed to the Standard of Care?

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Understanding Key Concepts

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Defining an Episode of Care

Establishing a beginning and an end to care; managing patient care in between.

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Active Treatment versus Maintenance Therapy

A treatment plan is required.

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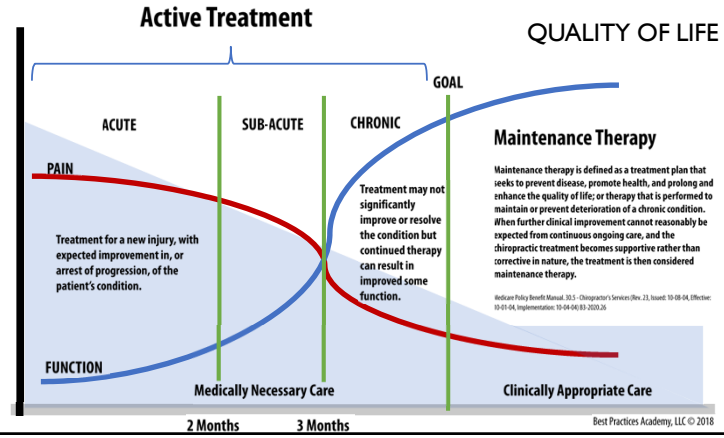

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Initial Visit

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History
Examination
Clinical Decision Making

Initial Visit Documentation Requirements

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The Intake Process

This process has now become *VERY* important because:

- It determines the Chief Complaint of the Patient
- It determines the Correct Evaluation & Management Code Selection
- It provides a key component of Medical Necessity

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Essentials of an Initial Visit

- Patient history (HPI, Review of Systems, and PFMSH)
- Mechanism of Trauma established
- Examination
- Informed Consent
- Problem/Diagnosis
- Treatment Plan
- Signature

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History

- ✓Chief Complaint(s)
- ✓History of Present Illness
- ✓Past Family Social Medical history
- ✓Review of Systems
- ✓Outcome assessments / Pain scales (VAS or NRS)

History containing **specific** functional limitations and restrictions/participation of daily activities and demands of employment

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Chief Complaint

The chief complaint should be the first notation in all medical records and is required for all levels of history.

It needs to be documented by the provider.

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Chief Complaint

The chief complaint should be the first notation in all medical records and is required for all levels of history.

It needs to be documented by the provider.

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Chief Complaint

Examples:

- *The patient presents today with a chief complaint of neck pain secondary to a motor vehicle accident.*
- *The patient presents today with a chief complaint of low back pain with radiation into the right posterior thigh.*
- *The patient states their chief complaint is in the mid-back and is achy in nature.*

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History of Present Illness (HPI)

The History of Present Illness (HPI) clarifies in more detail the patient's chief complaint...

- Symptoms/Complaints
- Mechanism of Trauma
- Location
- Date of Onset
- Quality
- Intensity
- Duration
- Frequency
- Radiation of Symptoms
- Aggravation
- Palliation
- Prior Intervention

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Mechanism of Trauma

Insidious Onset

Time Lapse of Treatment

Determining Causation

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Mechanism of Trauma

Symptoms corresponding and consistent with Mechanism of Trauma, Subluxation

AND

Function corresponding and consistent with Mechanism of Trauma, Symptoms, Subluxation, Goals of Care.

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How should you document this?

Insidious onset?

Cause unknown?

What if the patient can't recollect the cause of the onset?

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Common Area of Non-Compliance

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Mechanism of Trauma

Symptoms corresponding and consistent with Mechanism of Trauma, Subluxation

AND

Function corresponding and consistent with Mechanism of Trauma, Symptoms, Subluxation, Goals of Care.

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Rule out potential mechanisms and **document what didn't cause the condition**.

Document the initial date of treatment.

Mechanism of Trauma Etiology Unknown

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What other factors are involved?

Does the Mechanism of Injury Correlate with the Origin of Pain?

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What if there is a "gap in care" and causation is questioned?

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Who delays seeking care? Major factor: perceived expense of treatment

Delay is more common:

- Among people who have no regular contact with a physician
- When symptoms resemble past symptoms that proved to be minor
- If the primary symptom is atypical
- If the illness is associated with social stigma

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Key Questions to ask the patient

(document the answers)

- ✓Why was treatment not sought during this time?
- ✓Did anyone discuss their symptoms with them (patient education)?
- ✓Was the patient experiencing symptoms?
- ✓Was the patient on prescription or OTC medications?
- ✓Were any providers seen during this time, including massage therapy, etc.?
- ✓Were there any changes in lifestyle or Activities of Daily Living during this time?

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Fill the gap!

Document Reasons for Gap in Care in the History of Present Illness

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ROS

A complete Review of Systems (ROS) should be updated with each new episode or follow-up clinical encounters within 12 months.

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Review of Systems (ROS)

The 14 systems as per the *AMA CPT Code Book*:

1. Constitutional
2. Eyes
3. Ears, Nose, Mouth, Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/Lymphatic
14. Allergic/Immunologic

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Past Family Medical Social History (PFMSH)

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Past Family Medical Social History (PFMSH)

Past Family History

A review of the patient's family history to include any conditions or cause of death of parents, siblings, or children. This should include asking about diabetes, hypertension, cancer, or any other disease related to or that may delay recovery of the chief complaint.

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Past Family Medical Social History (PFMSH)

Past Medical History

A review of the patient's past medical history should include information on previous occurrences of the chief complaint, surgeries, fractures, traumas, treatments, medications, and home therapies.

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Past Family Medical Social History (PFMSH)

Past Social History

This should include information on marital status, occupation, educational level achieved, and current/previous use of alcohol, tobacco, and drugs.

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Factors or barriers which may lead to complicating the recovery time…

- ✓**Nature of employment/work activities or ergonomics**
- ✓**Impairment/disability**
- ✓**Concurrent condition(s) and/or use of certain medications**
- ✓**History of prior treatment**
- ✓**Lifestyle habits**
- ✓**Psychological factors**
- ✓**Transportation**
- ✓**Insurance Benefit Coverage**

Document in the clinical record!

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Outcome Assessment Tools

Physical and Behavioral

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Examination

The collection of diagnostic information discovered through physical applications such as orthopedic, neurological signs and tests, palpation, percussion, auscultation, and inspection.

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Physical Examination

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Examination Findings and Symptoms Correlation

Differentiate tissue involvement: Does it correlate to the mechanism of trauma?

Is the patient's **pain and symptoms reproduced** with testing of stressing the specific tissue involved?

Or is the pain reproduced through performing other tests or signs **during the physical exam**?

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Medicare Documentation

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned are required, one of which must be **asymmetry/misalignment** or **range of motion abnormality**.

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Initial Visit Medicare Requirement

Demonstrating a Subluxation

P.A.R.T

Diagnostic Imaging

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Demonstration of Subluxation by Radiographic Image (X-Ray)

- Image must be dated no more than 12 months prior to or 3 months following the initiation of the course of chiropractic care.
- Older x-rays for chronic subluxations caused by structural conditions.
- Condition must have been in existence longer than 12 months, established as a permanent condition.
- CT scan and/or MRI imaging is acceptable if a subluxation is demonstrated.

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Demonstration of Subluxation based on Physical Examination

- (P): Pain/tenderness evaluated in terms of location, quality, and intensity. Palpation findings of pain/ tenderness may be measured objectively and subjectively to quantify the objective finding(s) as a benchmark to future subsequent active treatment.
- (A): Asymmetry/misalignment identified on a sectional or segmental level. Palpation findings indicate a structural malposition of the vertebral segment.
- (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). Range of motion dysfunction of the spine region may be objectively quantified and rated against the normal degrees of motion for that region.
- (T): Tissue tone changes in the characteristics of contiguous or associated soft tissues include skin, fascia, muscle, and ligament. The palpatory findings of tissue tonicity, fibrotic nodules, and character of the tissue to establish a benchmark to rate treatment effectiveness of subsequent visits.

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Red Flags Immediate Referral

1. Fracture/dislocation
2. Cancer/tumor
3. Infection
4. Vertebrobasilar involvement
5. Instability (including degenerative, surgical, or rheumatoid etiologies)
6. Progressive scoliosis
7. Severe osteoporosis
8. Severe hypertension
9. Visceral pathology

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Cautious Considerations

1. Osteoporosis
2. Congenitally blocked vertebrae
3. Rheumatoid arthritis
4. Seronegative arthropathies
5. Spinal stenosis
6. Spinal instability (i.e. listhesis)
7. A diagnosis of disc herniation or sequestration
8. Previous surgery
9. Use of corticosteroids or Cushing's disease
10. Use of anticoagulant medication
11. Psychiatric disorder
12. Previous adverse reaction to a specific therapy or therapeutic trial
13. Positive response to vertebrobasilar testing other than neurological (e.g. dizziness that is postural or cervicogenic)

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Yellow Flag Behaviors

Two or more could suggest substance use disorder

- Deterioration in functioning at work or socially
- Illegal activities—selling medications, forging prescriptions, or buying medications from nonmedical sources
- Using medications in ways other than prescribed (e.g., injecting or snorting medication)
- Multiple reports of lost or stolen prescriptions
- Resistance to change in medications despite adverse effects
- Refusal to comply with random drug screens, call backs, or pill counts
- Concurrent abuse of alcohol or drugs Use of multiple physicians and pharmacies

Knowing When to Say When: Transitioning Patients from Opioid Therapy University of Massachusetts Medical School (Massachusetts Consortium) Jeff Baxter, M.D. April 2, 2014

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Pain assessment through examination should include **determining the origin of pain** through tissue specific localization, orthopedic, neurological, biomechanical evaluation **leading to a differential diagnostic clinical decision-making** process.

Pain Assessment through Examination

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Arriving at a diagnosis and Treatment Plan involves using Decision Support Tools, Critical Thinking

Processes, and an Evidence-informed Approach.

Medical Decision Making

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Key Questions for Medical Decision Making

How many problems exist and what is the complexity of each problem?

How much clinical data did we need to process?

Will there be any risks associated with management of the patient's problem?

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Clinical Decision Making (Must be supported by the clinical findings)

- Diagnosis
- Treatment plan: Goals, Duration, and Frequency (measurable and medically necessary)
- Treatment plan includes self-care instructions and active care recommendations.

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Risk Factors with Strong Predictive Ability for developing chronic pain and disability

- Fear avoidance beliefs
- Catastrophizing
- Somatization
- Depressed mood
- Distress and anxiety
- Early disability or decreased function
- High initial pain levels
- Increased age
- Poor general health status
- Non-organic signs
- Secondary gain (occupational, social, family, financial)

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Predictive Analysis

Differential Diagnosis

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Medical Necessity

Medical necessity is defined as services that are **reasonable and necessary** for the diagnosis or treatment of an illness or injury or to **improve the functioning** of a malformed body member and are not excluded under another provision of the Medicare Program.

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Problem/Diagnosis

ICD-10 Coding and Hierarchy Levels

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Informed Consent Process

Informing patients properly depends upon the sequence and information provided to disclose material risk.

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Shared Medical Decision Making

Engaging the patient and/or family preferences, patient and/or family education, and explaining risks, benefits, and alternatives for management of their condition.

(Informed Consent)

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Report of Findings

Report of findings following initial examination, re-evaluations, and relevant patient visits are

Opportunities for Education

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Report of Findings
A Collaborative Conversation

Report of Findings includes:

a. Diagnosis,
b. Recommended treatment plan,
c. Individualized patient goals, potential barriers, self care abilities,
d. Written instructions for self care,
e. Education, resources for treatment and self care
f. Answering patient questions!

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Report of Findings

- You are not selling the patient on care. You are a clinician delivering the facts.
- You are to be friendly, but you are not there to be their friend. Stay unbiased and objective.
- Report to the patient within the context of tissue involvement and healing response times. (i.e., muscle 2-4 weeks, bone 6-8 weeks, ligament 6-12 weeks, disc 12-24 weeks)
- Narrow it down for the patient. Keep it simple. Facilitate meaningful discussion leading to a decision.
- Correlate the report of findings with the financial plan (staff driven)

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Treatment Plan

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Treatment Plan

1. Specific Measurable Goals
2. Total Duration of Care
3. Total Frequency of Care

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Treatment Plan Triangulation

GOALS

Region Involved ⟷ ADL Limitation

Ask the questions:

1. Do these three components correlate to each other, and
2. Do these three components this correlate to the mechanism of trauma?

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Goal Categories

PAIN GOAL

ACTIVITY OF DAILY LIVING (SPECIFIC FUNCTIONS)

RANGE OF MOTION

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Specific Measurable Goals

How do we determine goals that are meaningful, quantifiable, measurable, and realistic?

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What level of improvement do you expect to achieve?

Begin with the Pre-Incident Status as the benchmark for your goal.

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Establishing Pre-incident Status

ADL, VAS, outcome tool values established prior to the condition.

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Pre-incident Status is the benchmark until or unless therapeutic gain has plateaued.

Specific measurable goals are benchmarked… and measured for performance.

95

Goal Selection

- ✓Correlate goals to the **mechanism of trauma**
- ✓Correlate goals to the patient's regional **symptoms**.
- ✓Correlate goals to the **pre-incident status**.

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EXAMPLE

Prior to onset of condition, the patient did not experience neck pain and could turn his head to the right without restrictions. Patient notes that due to the neck pain he can only sleep four hours without waking up. Current cervical ROM to left is 15 degrees and a pain scale rating of 9 was noted.

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Goals:

- Patient will be seen 3x a week for 4 weeks to decrease pain, increase ROM and cervical function.

Goals:

- Sleep 8 hours without waking up (ADL)
- Decrease VAS from 9 to 2
- Increase cervical rotational ROM to the left from 15 to 50 degrees.
- Duration to achieve goal will be 8 weeks at a frequency of 3x a week (24 total visits).

Generalized Goal
vs.
Specific Goal

98

A specific goal is NOT a % improvement from an Outcome Assessment Tool

99

Outcome Assessment Tools are used to determine and help validate Medical Necessity

100

How long will it take to achieve the specific measurable goals and return the patient to pre-incident status – or reach MTB?

Once the goal(s) have been chosen, then **determine the duration** it will take to accomplish the goal (**end of care**).

DURATION OF CARE

101

Tissue Differentiation

Healing Timeframes
Tension versus Compression Biomechanics

102

Barriers to Care

103

Factors which may lead to complicating the recovery time…

- ✓ **Nature of employment/work activities or ergonomics** The nature and psychosocial aspects of a patient's employment must be considered when evaluating the need for ongoing care (e.g. prolonged standing posture, high loads, and extended muscle activity).
- ✓ **Impairment/disability** The patient who has reached MTB, but has failed to reach pre-injury status has an impairment/disability even if the injured patient has not yet received a permanent impairment/disability award.
- ✓ **Concurrent condition(s)** and/or use of certain medications may affect outcomes.
- ✓ **History of prior treatment** Initial and subsequent care (type and duration), as well as patient compliance and response to care, can assist the physician in developing appropriate treatment planning. Delays in the initiation of appropriate care may complicate the patient's condition and extend recovery time.
- ✓ **Lifestyle habits** Lifestyle habits may impact the magnitude of treatment response, including outcomes at MTB.
- ✓ **Psychological factors** A history of depression, anxiety, somatoform disorder or other psychopathology may complicate treatment and/or recovery.

Document in the clinical record!

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Chronic Prognostic Factors

- ✓ Older age (pain and disability)
- ✓ History of prior episodes (pain, activity limitation, disability)
- ✓ Duration of current episode >1 month (activity limitation, disability)
- ✓ Leg pain [for patients having LBP] (pain, activity limitation, disability)
- ✓ Psychosocial factors [depression (pain); high fear-avoidance beliefs, poor coping 354 skills (activity limitation); expectations of recovery]
- ✓ High pain intensity (activity limitation; disability)
- ✓ Occupational factors [higher job physical or psychological demands (disability)]
- ✓ Other factors or comorbidities not listed above may adversely affect a given patient's prognosis and management.

Document in the clinical record!

105

105

How many visits will you need to achieve the specific measurable goals within the already determined duration?

FREQUENCY OF CARE

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Treatment Plan Goal Summary

- **PreIncident** — Review what was patient's status prior to the onset to determine what is reasonable status to set a goal for.
- **Mechanism** — Review mechanism of trauma and correlate the goals to the trauma mechanism and specific vertebrae/body region affected.
- **Start** — Start with ADL goal and make it specific, measurable or in a way that can be quantified for progress.
- **Goals** — Add in physical goals such as Pain, ROM or others and use numbers to quantify the starting point and specific desired end point.
- **Duration** — Determine the duration of time it will take you to achieve the goals.
- **Frequency** — Determine the frequency you will need to treat the patient within the established durational timeframe.

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Evidence-based clinical practice

"The approach to decision-making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best."

Gray JAM. 1997. **Evidence-based healthcare: how to make health policy and management decisions.** London: Churchill Livingstone.

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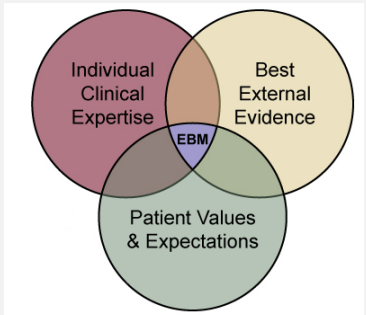
108

Evidence-based Practice



The Evidence-based Medicine Triad
Source: Florida State University, College of Medicine.

Retrieved 5-16-13

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Care Management

Patients without "red flag" indicators may undergo an initial trial of chiropractic care for a period of 10-14 days. Frequency may range from 2-5 (or daily) visits per week.

Emphasis should be placed on the following:

1. Avoidance or modification of aggravating activities such as employment or activities of daily living (ADL). This may include ergonomic advice, work restriction or temporary work absence.
2. Self-care instruction
3. Passive care approaches
4. Early introduction of active care approaches

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Passive care approaches including one or more of the following:

- Manipulative therapy
- Physical therapy modalities
- Soft tissue techniques
- Anti-inflammatory or anti-spasmotic dietary supplementation including enzymes or herbs

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111

Chiropractic Techniques

Chiropractic technique approaches vary, and the choice of which technique is appropriate for the patient will be determined by the clinician based on various needs including age, risk factors to manipulation, expertise of the clinician and patient preference.

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Best Practices Academy has adopted CCGPP Treatment Frequency Guidelines and Terminology for Stages of Care

The following is direct from the CCGPP Guidelines…

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Condition Stages
Timelines

- Acute—symptoms persisting for less than 6 weeks.
- Subacute—symptoms persisting between 6 and 12 weeks.
- Chronic—symptoms persisting for at least 12 weeks.
- Recurrent/flare-up—return of symptoms perceived to be similar to those of the original injury at sporadic intervals or as a result of exacerbating factors.

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Acute Conditions

- Medically necessary care of acute conditions is care that is reasonable and necessary for the diagnosis and treatment of a patient with a health concern and for which there is a therapeutic care plan and a goal of functional improvement and/or pain relief.
- The result of the care is expected to be an improvement, arrest, or retardation of the patient's condition.
- Initially, the care may be more frequent, but as levels of improvement are reached, a decrease in the frequency of care is to be expected.
- A patient may experience exacerbations of an acute injury/illness being treated that may clinically require an increased frequency of care for short periods of time.
- A patient may also experience a recurrence of the injury/illness after a quiescence of 30 days that may require a reinstitution of care.

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Chronic/Recurrent Conditions

- Medically necessary care of recurrent/chronic conditions is care that is provided when the injury/illness is not expected to completely resolve after a treatment regimen but where continued care can reasonably be expected to result in documentable improvement for the patient.
- When functional status has remained stable under care and further improvement is not expected or withdrawal of care results in documentable deterioration, additional care may be necessary for the goals of supporting the patient's highest achievable level of function, minimizing or controlling pain, stabilizing injured or weakened areas, improving activities of daily living, reducing reliance on medications, minimizing exacerbation frequency or duration, minimizing further disability, or keeping the patient employed and/or active.
- Chronic/recurrent care may be inappropriate when it interferes with other appropriate primary care or when its benefits are outweighed by its risks, for example, psychological dependence on the physician or treatment, illness behavior, or secondary gain.

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Recommended Evidence-informed Clinical Care Guidelines

1. The State Codified Laws;
2. The policies adopted by the State Board of Chiropractic Examiners;
3. The procedures for performance of peer reviews of the State Board of Chiropractic Examiners or state law;
4. The guidelines set forth by the State rules and regulations for the practice of chiropractic in the state;
5. Guidelines for Chiropractic Quality Assurance and Practice Parameters; Proceedings of the Mercy Center Consensus Conference;
6. United States Preventive Services Task Force (USPSTF) recommendations
7. American Chiropractic Association code of ethics;
8. The most current procedural terminology codes of the American Medical Association Guidelines;
9. The most current CPT coding compliance and documentation manual;
10. Council for Chiropractic Guidelines and Practice Parameters (CCGPP) Clinical Guidelines: http://clinicalcompass.org/category_ccgpp/scientific-studies

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Implementing the Care Plan…

- Proper documentation in patient record
- Providing care summaries at each relevant patient visit
- Reassessing progress through period re-evaluations
- Identifying barriers to goals if not met
- Review of preventive timeline and high risk factors

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12-13

https://www.menti.com/al279xf862ga

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E/M Visit Coding

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NEW PATIENT

A new patient is one who **has not received** any professional services from a physician, or another physician of the same specialty who belongs to the same group practice, within the *past three years.*

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ESTABLISHED PATIENT

An established patient is one **who has received** professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

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Who is not a New Patient?

- ✓Any patient who has been under your care, or another physician in your group, within the past three years, no matter if they have a new injury or new insurance, *IS NOT A NEW PATIENT.*
- ✓A patient who was previously under care, but who is currently involved in either an auto or worker's compensation case.

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Deletion of CPT code 99201

(Level 1 office/outpatient visit, new patient)

Eliminated because CPT codes 99201 and 99202 are both straightforward MDM and currently largely differentiated by history and exam elements.

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99211

May not require the presence of a physician – presenting problem(s) are minimal.

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99202 through 99215 Office/Outpatient E/M Visits

Selection of the code level to report will be based on either the level of **MDM or the Total Time** personally spent by the reporting practitioner on the day of the visit (including face-to-face and non-face-to- face time)

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Essentials of an Initial Visit

- Patient history (HPI, Review of Systems, and PFMSH)
- Mechanism of Trauma established
- Examination
- **Medical Decision Making**
- Informed Consent
- Problem/Diagnosis
- Treatment Plan
- Signature

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Medical Decision Making

(the clinical thought process)

Differential Diagnosis

Treatment plan:

✓Goals
✓Duration
✓Frequency

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Differential Diagnosis

Elements involved in a clinical assessment of the patient's problem(s)

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Determining the Complexity of Medical Decision Making

OF POSSIBLE DIAGNOSES/PROBLEMS CONSIDERED IN THE PROCESS OF DIFFERENTIAL DIAGNOSIS

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED WHICH PROVIDES SPECIFIC DIAGNOSTIC ITEMS TO BE REVIEWED AND/OR ORDERED; I.E. MEDICAL RECORDS, DIAGNOSTIC TESTS, ETC.

CALCULATING RISK:

THE NATURE OF THE PRESENTING PROBLEM:

DIAGNOSTIC PROCEDURES ORDERED

MANAGEMENT OPTIONS SELECTED

TYPES OF MEDICAL DECISION MAKING:

STRAIGHTFORWARD

LOW COMPLEXITY

MODERATE COMPLEXITY

HIGH COMPLEXITY

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Medical Decision Making is based upon…

1. Number and Complexity of **Problems** Addressed at the Encounter
2. Amount and/or Complexity of **Data** to be Reviewed and Analyzed
3. **Risk** of Complications and/or Morbidity or Mortality of Patient Management

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Key Questions for Medical Decision Making

How many problems exist and what is the complexity of each problem?

How much clinical data did we need to process?

Will there be any risks associated with management of the patient's problem?

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Medical Decision Making is based upon…

1. **Number and Complexity of Problems Addressed at the Encounter**
2. Amount and/or Complexity of Data to be Reviewed and Analyzed
3. Risk of Complications and/or Morbidity or Mortality of Patient Management

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How complex is the problem(s)?

What is a problem?

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Problem

A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter

addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

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Levels of Problem Complexity

1. Minimal Problem
2. Self-limited or Minor Problem
3. Acute, Uncomplicated Illness or Injury
4. Acute, Complicated Injury
5. Stable, Chronic Illness
6. Chronic Illness with Exacerbation, Progression, or Side Effects of Treatment

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Minimal Problem

A problem that may not require the presence of the physician or other qualified health care professional.

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Example: low back pain without leg pain, acute or subacute.

Self-limited or Minor Problem

A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

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Example: a strain injury causing acute low back pain without leg pain.

Acute, Uncomplicated Illness or Injury

A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected.

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Example: a strain/sprain injury resulting from a MVA causing acute neck pain with radiation to the arm, headaches, and loss of neurological function.

Acute, Complicated Injury

An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

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Example: chronic recurring low back pain complicated by degenerative disc disease at L4/5 levels.

Stable, Chronic Illness

A problem with an expected duration of at least a year or until the death of the patient.

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Example: acute low back pain with radiculopathy complicated by degenerative disc disease at L4/5 levels and chronic pain syndrome.

Chronic Illness with Exacerbation, Progression, or Side Effects of Treatment

A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care.

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Based on the number and complexity of the existing problem(s), define the problem's level of status.

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Straightforward
99202/99212

Minimal complexity characterized by **ONE** self-limited or minor problem.

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Low
99203/99213

Low level of complexity characterized by **EITHER**:
TWO or more self-limited or minor problems
OR
ONE stable chronic illness
OR
ONE acute, uncomplicated illness or injury

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Moderate
99204/99214

Moderate level of complexity characterized by **EITHER**:
ONE or more chronic illnesses with exacerbation, progression, or side effects of treatment
OR
TWO or more stable chronic illnesses
OR
ONE undiagnosed new problem with uncertain prognosis
OR
ONE acute illness with systemic symptoms
OR
ONE acute complicated injury

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High
99205/99215

High level of complexity characterized by **EITHER**:
ONE or more chronic illnesses with severe exacerbation, progression, or side effects of treatment
OR
ONE acute or chronic illness or injury that poses a threat to life or bodily function

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Medical Decision Making is based upon…

1. Number and Complexity of Problems Addressed at the Encounter
2. **Amount and/or Complexity of Data to be Reviewed and Analyzed**
3. Risk of Complications and/or Morbidity or Mortality of Patient Management

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How much clinical data did we need to process?

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How much clinical data did we need to process?

History
Examination
Ordering Tests
Diagnostic Imaging/Lab Findings
External Records
Independent Interpretation
Independent Historian
Discussion of Management

150

Independent Interpretation

The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

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Services Reported Separately

Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/ studies (i.e., professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

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Independent Historian(s)

An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary.

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Discussion of Management

Discussions with other providers regarding the management of a patient's condition is not counted in the MDM when selecting an E/M code. It will qualify as a separate office or outpatient service.

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Straightforward
99202/99212

Minimal to none.

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Low
99203/99213

Limited, meeting ONE of two requirements:

Tests and Documents with TWO of the following:

- ✓ Review of external notes from each unique source
- ✓ Review of results of each unique test
- ✓ Ordering of each unique test

OR

Assessment requiring an independent historian

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Moderate
99204/99214

Moderate, meeting **ONE** of three requirements:

Tests, Documents, or independent historian(s) with any THREE of the following:

- ✓ Review of external notes from each unique source
- ✓ Review of results of each unique test
- ✓ Ordering of each unique test
- ✓ Assessment requiring an independent historian

OR

Independent Interpretation of Tests performed by another physician/qualified health care professional

OR

Discussion of management or test interpretation with external physician or qualified health care professional/appropriate source

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High
99205/99215

Extensive, meeting **TWO** of three requirements:

Tests, Documents, or independent historian(s) with any THREE of the following:

- ✓ Review of external notes from each unique source
- ✓ Review of results of each unique test
- ✓ Ordering of each unique test
- ✓ Assessment requiring an independent historian

OR

Independent Interpretation of Tests performed by another physician/qualified health care professional

OR

Discussion of management or test interpretation with external physician or qualified health care professional/appropriate source

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Medical Decision Making is based upon…

1. Number and Complexity of Problems Addressed at the Encounter
2. Amount and/or Complexity of Data to be Reviewed and Analyzed
3. **Risk of Complications and/or Morbidity or Mortality of Patient Management**

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Will there be any risks associated with management of the patient's problem?

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Risk

The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration.

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Table of Risk

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Minimal	• One self-limited or minor problem (for example, cold, insect bite, tinea corporis)	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound (for example, echocardiography) • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness (for example, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH) • Acute uncomplicated illness or injury (for example, cystitis, allergic rhinitis, simple sprain)	• Physiologic tests not under stress (for example, pulmonary function tests) • Non-cardiovascular imaging studies with contrast (for example, barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives

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LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis (for example, lump in breast) • Acute illness with systemic symptoms (for example, pyelonephritis, pneumonitis, colitis) • Acute complicated injury (for example, head injury with brief loss of consciousness)	• Physiologic tests under stress (for example, cardiac stress test, fetal contraction stress test) • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors (for example, arteriogram, cardiac catheterization) • Obtain fluid from body cavity (for example, lumbar puncture, thoracentesis, culdocentesis)	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation

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LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function (for example, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure) • An abrupt change in neurologic status (for example, seizure, TIA, weakness, sensory loss)	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

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Social Determinants of Health

Moderate Level of Risk

Diagnosis or treatment is significantly limited by social determinants of health

(i.e., economic and social conditions that influence access to care, etc.)

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Based on the risks associated with patient management, define the problem's level of status.

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Straightforward

99202/99212

Minimal risk of morbidity from additional diagnostic testing or treatment.

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Low
99203/99213

Low risk of morbidity from additional diagnostic testing or treatment.

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Moderate
99204/99214

Moderate risk of morbidity from additional diagnostic testing or treatment.

Examples:

Prescription drug management

Minor or elective surgery procedures

Diagnosis or treatment limited by social determinants of health

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High
99205/99215

High risk of morbidity from additional diagnostic testing or treatment

Examples:

Drug therapy requiring monitoring

Surgery with patient risk factors

Emergency procedures/hospitalizations

Decision to not resuscitate or to de-escalate care due to poor prognosis

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What would you code the following?

- Number and Complexity of Problems Addressed at the Encounter
  - LOW (One acute, uncomplicated illness or injury)
- Amount and/or Complexity of Data to be Reviewed and Analyzed
  - MODERATE (reviewed external notes, reviewed results of tests, ordered x-rays)
- Risk of Complications and/or Morbidity or Mortality of Patient Management
  - LOW (Low risk of morbidity from additional diagnostic testing or treatment.)

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What would you code the following?

- Number and Complexity of Problems Addressed at the Encounter
  - LOW (One acute, uncomplicated illness or injury)
- Amount and/or Complexity of Data to be Reviewed and Analyzed
  - MODERATE (reviewed external notes, reviewed results of tests, ordered a test)
- Risk of Complications and/or Morbidity or Mortality of Patient Management
  - LOW (Low risk of morbidity from additional diagnostic testing or treatment)

Low
99203/99213

To qualify for a particular level of medical decision making, two of the three elements for that level of medical decision making must be met or exceeded.

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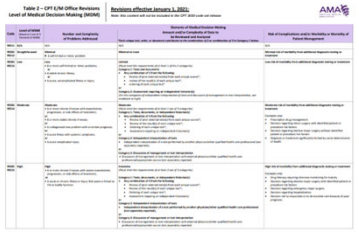
CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf



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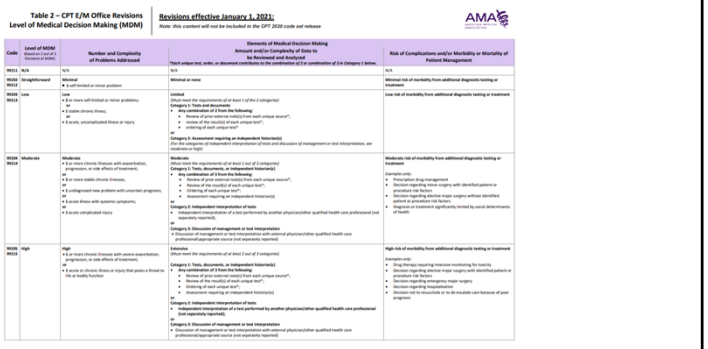

Table 2 – CPT E/M Office Revisions Level of Medical Decision Making (MDM) | **Revisions effective January 1, 2021:** *Note: this content will not be included in the CPT 2020 code set release*

Code	Level of MDM (Code based on 2 of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed (*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.)	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment
99204 99214	Moderate	Moderate • 3 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate (Must meet the requirements of at least 2 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	High • 4 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 3 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (Must meet the requirements of at least 3 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);	High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

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"If you don't have sufficient complexity to code by MDM, then you have an alternative."

Barbara Levy, MD
Co-Chair, CPT/RUC E/M Work Group
https://www.youtube.com/watch?v=FdyqEAvxt1k&feature=emb_rel_end

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Total Time

- ✓Preparing to see the patient (reviewing tests, etc.)
- ✓Obtaining or reviewing separately obtained history
- ✓Performing examination and/or evaluation
- ✓Counseling and educating the patient/family/caregiver
- ✓Ordering tests, procedures
- ✓Referring or communicating with other providers
- ✓**Documenting clinical information in the electronic or other health record**
- ✓Independently interpreting results and communicating result to the patient/family/caregiver
- ✓Care coordination

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History and Examination

The extent of the history and examination is no longer an element in the selection of an evaluation and management code of office or other outpatient services.

The nature and extent of the history and physical examination is solely determined by the clinician reporting the service.

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Clear and Concise Documentation

Quality care
Mitigates malpractice risk
Validates coding
Treatment plan
Guards against wrongful billing

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Office and Outpatient E/M Services
Total Time on Date of Encounter

New Patient E/M Code	Total Time
99202	15-29 minutes
99203	30-44 minutes
99204	45-59 minutes
99205	60-74 minutes

Established Patient E/M Code	Total Time
99212	10-19 minutes
99213	20-29 minutes
99214	30-39 minutes
99215	40-54 minutes

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New Office/Outpatient E/M Prolonged Visit CPT code 99XXX

CPT code 99XXX could be reported when the maximum time for the level 5 office/outpatient E/M visit is exceeded by at least 15 minutes on the date of service.

If this is used, documentation will be important to valid time spent with the patient over and above the 99205/99215 levels.

https://www.cms.gov/files/document/cms-1734-p-pdf.pdf

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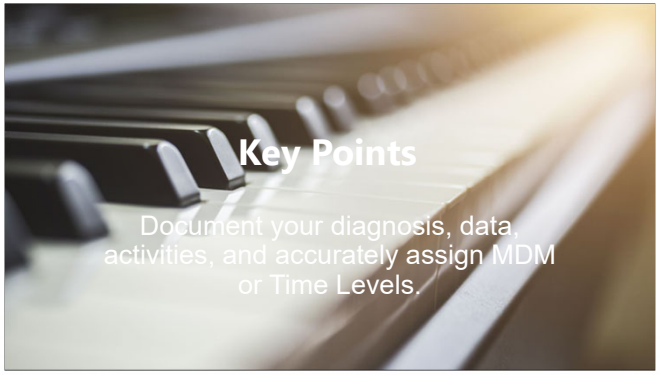

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Financial Analysis

1. Will the patient encounter allow you to efficiently work through clinical activities in less time to achieve a higher level of coding than if you use total time as the criteria?
2. Will your EHR system document MDM or time to validate your coding selection?
3. What will be the impact on practice revenue with this change in coding?

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Whether Time or MDM is used to bill the E/M code, practitioners will document the medical necessity of the office/outpatient E/M visit

Documentation, documentation, documentation…

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References

- Federal Register / Vol. 85, No. 159 / Monday, August 17, 2020 / Proposed Rules Effective January 1, 2021 https://www.cms.gov/files/document/cms-1734-p-pdf.pdf
- CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes. https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf
- CPT E/M Office Revisions Level of Medical Decision Making (MDM) https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf
- Evaluation and Management Service Guide ICN 006764 January 2020 CMS MLN Booklet https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf

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Common Area of Non-Compliance

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Modifier -25

Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

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Under-Coding or Discounting E/M visits

Both are considered Inducement

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Documentation Self-Audit

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Initial Examination & Re-examination Note Audit Checklist

HEALTH HISTORY	YES	NO
HPI per Chief Complaints Noted?		
Mechanism of Onset/Trauma identified?		
Pertinent PFMSH and ROS Noted?		
Pain Intensity and Quality Noted?		
Specific ADL limitations Noted?		
Failed Treatment History Noted?		
Pain Outcome Assessment Tool Completed?		
Function Outcome Assessment Tool Completed?		
INITIAL EXAM/RE-EXAM DOCUMENTATION	**YES**	**NO**
Vitals Completed?		
Orthopedic Eval Completed?		
Neuro Eval Completed?		
Palpatory Eval Completed?		
Radiographic Eval & Report Completed?		
Problem/DX Assigned?		
Does the exam support the diagnosis?		
DME: Indications Completed?		
Charge Capture: Accurate Coding Completed?		
Progress Report Completed (Re-Exam Only)?		
TREATMENT PLAN	**YES**	**NO**
SPECIFIC Long-term Goals Established (Pain, Function, Objective)?		
Does it list measurable goals per Chief Complaint?		
Diagnosis on chart note consistent with treatment plan?		
Does it list Type, Frequency, and Duration of Treatment?		
Treatment Plan (per procedure) Completed?		
Informed Consent		
Procedure Identified in Consent Correctly?		
Signed by Patient?		
Signed by Provider?		
Re-Examination Date Established?		
Re-Exam: Plan of Care Updated?		
Re-Exam: Failed Therapy with New Indication?		
Patient Instruction/Education Documented?		
CHARGE CAPTURE	**YES**	**NO**
Problem/DX Assigned?		
CPT Codes Extracted?		
Do the CPT Codes Correlate with the ICD Codes?		
CPT/ICD Codes Linked?		
Note Signed?		

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Subsequent Visit

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https://www.menti.com/al279xf862ga

14-20

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How are we managing patient care throughout the episode of care?

Subsequent Visits

194

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Documentation Requirements: Subsequent Visits

SUBJECTIVE (History):

- Review of chief complaint; Always discuss the **symptoms** associated with the chief complaint.
- "**Changes since last visit**" are good key words to have in your documentation.
- Monitor the **pain level** goals in this section. If using the VAS system, it is positive to note the numerical changes in this section.
- Monitor and specifically note the progress involved in the **ADL limitation** goals that were set in the initial visit treatment plan.

Be Encounter Specific!

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Documentation Requirements: Subsequent Visits

OBJECTIVE (Physical exam):

- Exam of area of spine involved in diagnosis; The exam is based on the **CMT level exam** not an EM level examination.
- Assessment of **change in patient condition** since last visit;
- Evaluation of **treatment effectiveness**. (functional goal improvement)

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Documentation Requirements: Subsequent Visits

Key points for Subsequent visits:

- Primarily a **therapeutic visit**
- Continue to **compare** the current visit to the last visit
- Review and comment on the **progress** of the specific measurable goals created in the treatment plan

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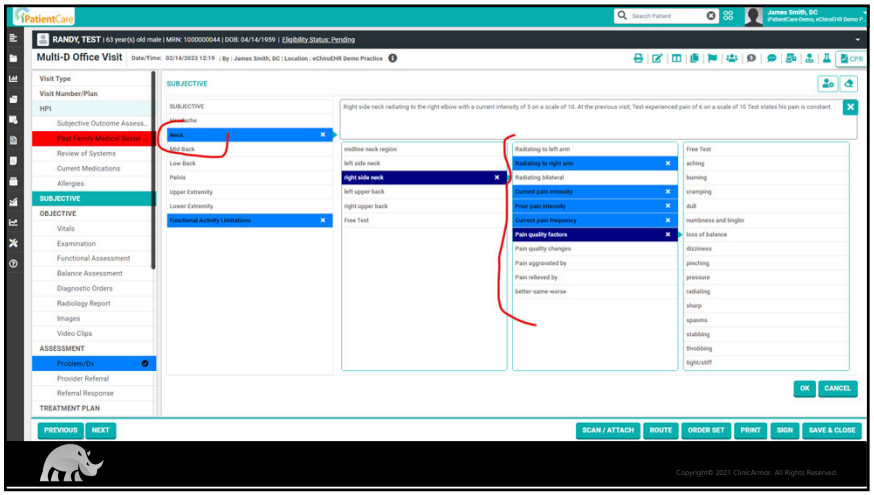

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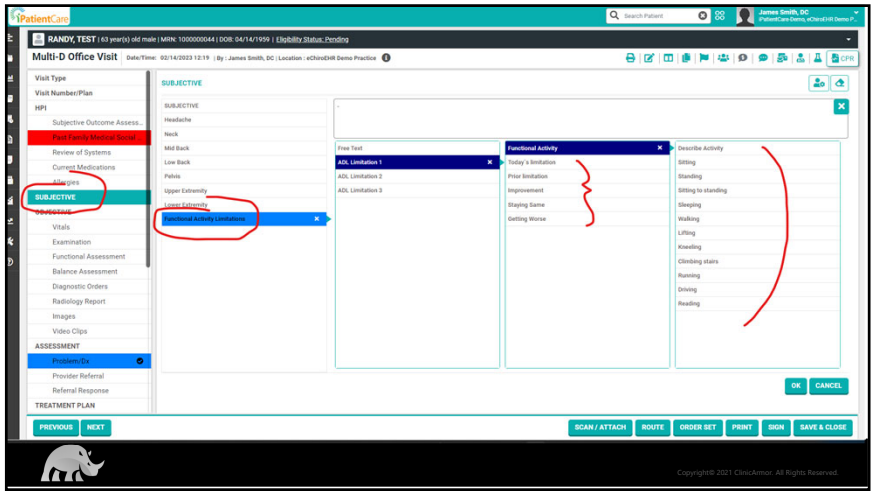

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Common Area of Non-Compliance

200

CMS Comments

"Default documentation is a problem because it is difficult to tell what work was actually provided for the current visit."

"Medical necessity documentation is a cognitive process that is difficult to document with templates and macros."

"The volume of documentation should not influence the selection of the visit code."

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EHR templates are meant to prompt physician documentation.

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Caution!!

Cloned notes may meet coding criteria but are not medically necessary if nothing changes from visit to visit.

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Erroneous, contradictory, or cloned information

Potential for fraud
Lack of medical necessity
Patient care issues

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When should a note be signed by the provider?

To maintain authenticity of the patient record, it is recommended to be completed within 24-72 hours of the date of the encounter and prior to the submission of a claim for services rendered during the encounter.

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"Many systems do support administrative controls that mitigate or eliminate some impeachment hazards such as automated administrative closure **twenty four to forty-eight hours** after record origination. This function, if enabled and not overridden ensures that amendments or corrections to the record thereafter are performed correctly and preserving the originally rendered information intact."

https://lawreview.avemarialaw.edu/wp-content/uploads/2019/06/v12i2.Gelzer.pdf

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How do we demonstrate treatment effectiveness?

Quantify and Measure

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Update Subjective Pain Intensity and Function on Each Visit

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Subjective Changes since the last visit…

- Pain Level using VAS
- Aggravating Factors
- ADL Limitation

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Update Objective Findings

When palpation reveals changes since the last visit…

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- Palpatory findings
- ROM
- Ortho findings, etc.

Objective Changes since the last visit…

How do we demonstrate treatment effectiveness?

212

212

Treatment Visit Coding

213

213

CMT Codes

98940	1-2 Spinal Regions
98941	3-4 Spinal Regions
98942	5 Spinal Regions
98943	Extraspinal Regions

Levels of CMT must be validated through documentation of regional symptoms, examination findings, and listed in the diagnosis

214

214

Each chief complaint represents a region of involvement.

Example: Documentation necessary to support CMT to 3-4 regions

3-4 regions identified as Chief Complaints documented independently

3-4 regions of objective findings

3-4 regions of diagnosis

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EACH REGION MUST CORRELATE TO THE MECHANISM OF INJURY AND DEMONSTRATE RELEVANCE WITHIN THE FOLLOWING CRITERIA:

Subjective Findings
Symptoms
Function

Objective Findings
Palpatory Findings

Diagnosis

Procedure

216

216

In other words, if you are performing a 5 region CMT (98942), then there must be symptoms, function, objective findings, diagnosis documented for 5 regions…

217

217

Time-based Codes

Documentation Parameters

218

218

Commonly Used Time-based Codes

Modalities
97032
97035
Therapeutic Procedures
97110
97112
97113
97116
97530
97124
97140
97535

The amount of time for each specific modality and therapeutic procedure provided to the patient should be documented in the subsequent visit notes under procedure section.

219

219

Time-based therapy codes

Time-based therapy codes require the provider to have direct contact with the patient and are reported once for each 15 minutes of service.

One-on-one contact (constant attendance) is defined as "the provider is required to maintain visual, verbal, and/or manual contact with the patient." Guided or Direct Cues documented as appropriate.

The therapy treatment documentation must include the total number of minutes spent treating the patient for each modality or the beginning and end times of each treatment.

At least eight minutes of therapy must be performed to charge for one unit of any of the time-based codes.

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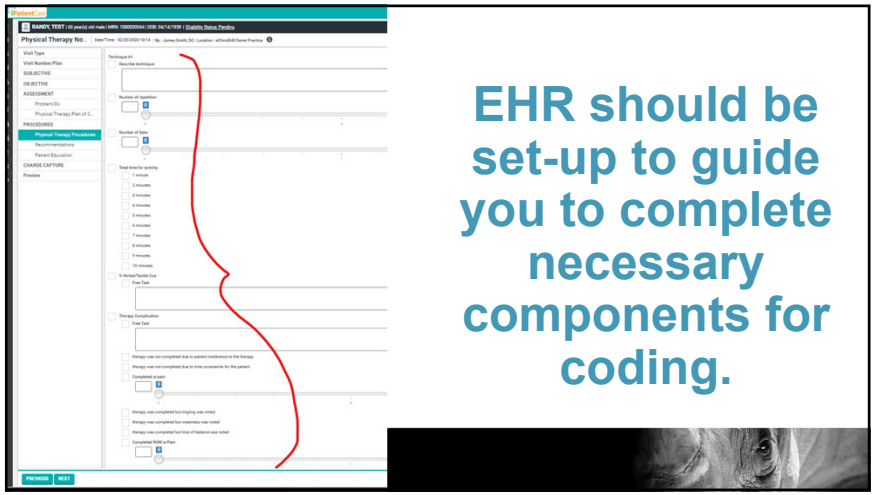

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Time-based Therapy Codes

1 unit = 8-22 minutes
2 units = 23-37 minutes
3 units = 38-52 minutes
4 units = 53-67 minutes

If a service represented by a 15-minute timed code is performed in a single day for at least 15 minutes, bill at least one unit. If the service is performed for at least 30 minutes, bill at least two units, etc.

222

97140

Manual therapy techniques	**(97140 *Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes*)**	**Includes soft tissue and joint mobilization, manipulation, manual lymphatic drainage, manual traction, trigger point therapy (non-injectable), and myofascial release.**

Manual therapy techniques are used to treat restricted motion of soft tissues in the extremities, neck, and trunk, and are used in an active and/or passive fashion to effect changes in the soft tissues, articular structures, neural, or vascular systems.

223

223

Use of 9894X Codes and 97140

224

97140 Rule

Document only the regions manipulated/adjusted in the procedure section and identify the region, muscle groups where manual therapy technique was performed and the technique and total time – as well as who performed the procedure if it wasn't the doctor.

225

97032

Therapeutic procedure	CPT® guidance for 97032 Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	Electrical stimulation therapy uses electricity to stimulate the muscles for the treatment of pain and other disorders associated with muscles, requiring constant attendance. This relieves pain, improves range of motion, muscle strength, reeducates muscles, stimulates wound healing, and reduces muscle spasm by activating or suppressing functions within nerves, muscles, soft tissue and bone cells.

226

226

Do not bill for both ultrasound and electrical stimulation for the same time period

Ultrasound with electrical stimulation provided concurrently should be billed as ultrasound (97035)

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97750

Therapeutic procedure	CPT® guidance for 97750 Physical performance test or measurement (i.e., musculoskeletal, functional capacity), with written report, each 15 minutes	The provider evaluates the patient based on individual needs, such as level of pain, sensation, and grip strength, as well as mobility activities like walking, crawling, and climbing. Provider checks activities related to positional tolerance like standing, sitting, and stopping, and those related to strength like lifting, pushing, and pulling. The provider then documents in a written report the details of the tests performed, results, and treatment options. Provider instructs the patient about activities such as those related to work and safety.

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Establishes Medical Necessity for Rehab and a Baseline to document improvement at Re-evals

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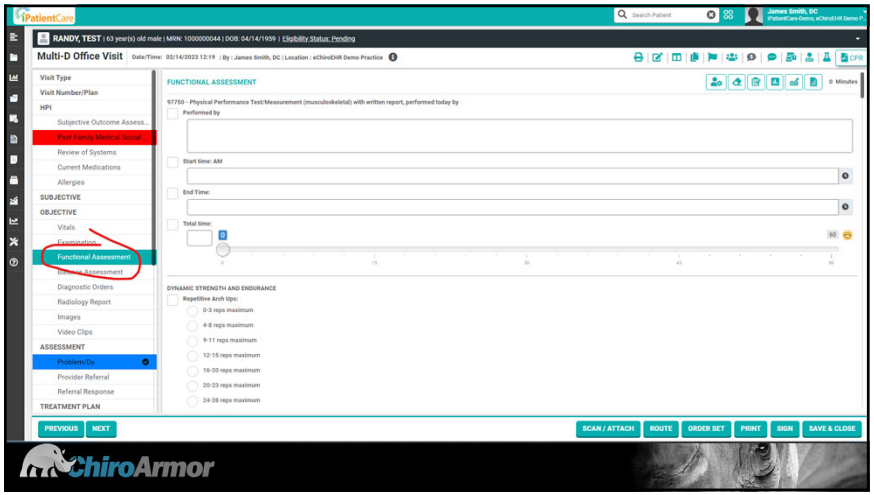

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WHAT ARE THE DIFFERENCES BETWEEN THERAPEUTIC EXERCISES AND ACTIVITIES?

- In differentiating between the two, it helps to think of therapeutic exercises as a **path** to therapeutic activities.
- When a patient is expected to reach **multiple outcomes** by performing their therapeutic movements, they are engaging in a **therapeutic activity**. When only one outcome is expected, they are performing a therapeutic exercise.

231

Must answer the question: "Is a skilled service required?"

In other words, is this something the patient can just do at home without a skilled therapist…

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232

Urquhart JR, Skidmore ER. Guided and directed cues: developing a standardized coding scheme for clinical practice. OTJR (Thorofare N J). 2014 Fall;34(4):202-8. doi: 10.3928/15394492-20141006-05. PMID: 25347758; PMCID: PMC4211290.

Guided and Directed Cues

Therapist-patient interaction is a key component of rehabilitation training. An important part of therapist-patient interaction is the delivery of cues, which may be in the form of instruction, guidance, and feedback.

233

Research suggests that progressive reduction in frequency of feedback cues leads to improved retention of learning.

234

Guided Cues

Guided Cues is training comprised of enabling a patient to discover a strategy or plan to solve a problem. The cueing can include open-ended questions and open-ended statements used to facilitate a patient's independent planning and problem solving (Swanson, 2001).

235

Directed Cues:

Verbal, Visual, Tactile

Directed Cues can be formulated as an instructional statement or a command that is used by the therapist during training as a means to elicit a specific, desired behavior. For example, a therapist may point to a specific item they want the patient to attend to, or they would demonstrate how to perform a task.

236

Verbal Cues

Verbal cues are used when a therapist provides a verbal reminder that helps the patient complete his or her task.

237

Visual Cues

Visual cues are used when a therapist provides a visual reminder that helps the patient complete his or her task.

238

Tactile Cues

(vibration, touch, pressure, stretching, tension)

Tactile cues are used when a therapist uses physical touch to guide a patient towards successful completion of a therapy objective:

- Afferent sensory input to the central nervous system
- Proprioceptive feedback, guiding the developing movement
- Tactile-kinesthetic stimulation are able to increase local motor activity and alertness while also providing a calming effect, reducing hypertonicity and regulating respiration.

Gilakjani, Abbas Pourhosein. "Visual, Auditory, Kinaesthetic Learning Styles and Their Impacts on English Language Teaching." *Journal of Studies in Education* 2.1 (2011): 104-113.
Field, Tiffany M., et al. "Tactile/kinesthetic stimulation effects on preterm neonates." *Pediatrics* 77.5 (1986): 654-658.

239

Vibration Cues

When a therapist uses a vibrating device on a muscle to facilitate a contraction or to increase awareness of the activation of the muscles.

240

Touch Cues

This is when you would provide a light touch or tap on a patient's muscle to bring awareness to where the patient should focus for the contraction or the movement.

241

Pressure Cues

Instead of just a touch the therapist applies pressure to a muscle or extremity for correct facilitation or to maintain a position.

242

Stretching Cues

When the therapist stretches a muscle for feedback and correct activation and to increase the range of motion.

243

Tension Cues

When you provide tension to the muscle with manual resistance or using a resistance band.

244

How to Show Progress With Tactile Cues

- Patient originally required tactile, visual, and verbal cues, however, now only requires tactile cues
- Patient was requiring tactile cues for 75% of the task, however, now they only require tactile cues for 25% of the activity
- Patient required pressure or a prolonged stretch to facilitate the correct muscle, however, now they only require a slight tap

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Document the cue type and % of the time cues were used during the session.

You can also document the % at the beginning of the session and the % at the end in the event there was a "fading" need for the cues as the session progressed.

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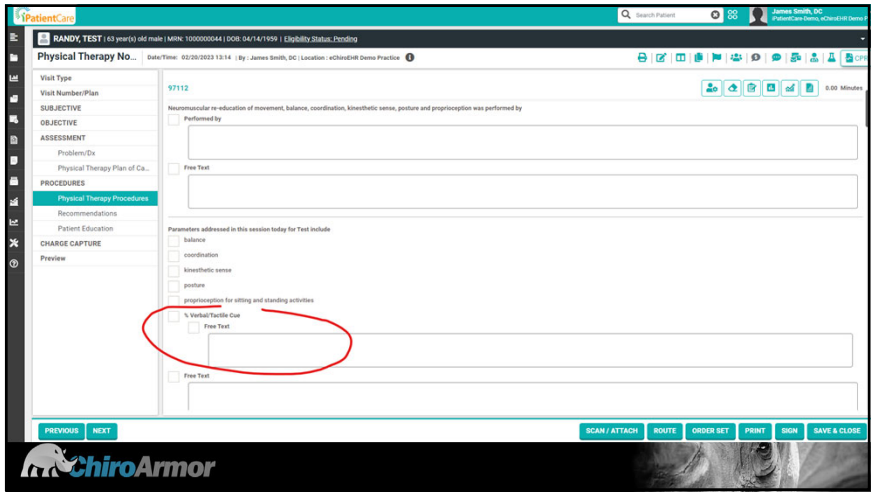

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97110

Therapeutic procedure	**CPT® guidance for 97110 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility:**	**Therapeutic exercise incorporates one parameter (strength, endurance, range of motion or flexibility) to one or more areas of the body. Examples include treadmill (for endurance), isokinetic exercise (for range of motion), lumbar stabilization exercises (for flexibility), and gymnastic ball (for stretching or strengthening).**

The goal of improving one of the following; strength, endurance, range of motion, or flexibility through exercise service makes a rehabilitative service a therapeutic exercise.

248

248

97110

One example:

Exercises such as a gymnastic ball is performed with the intent of improving a single parameter (strength, endurance, range of motion, or flexibility) the exercise is reportable using 97110, assuming the time and contact requirements are met.

249

97110

Documentation must show objective loss of joint motion, strength, or mobility (e.g., degrees of motion, strength grades, levels of assistance). Therapeutic exercises are used to increase range of motion, flexibility, endurance, and strength.

250

Common Documentation Error

97110 not supported due to lack of establishing parameters, time, reps/sets performed, by whom it was performed by

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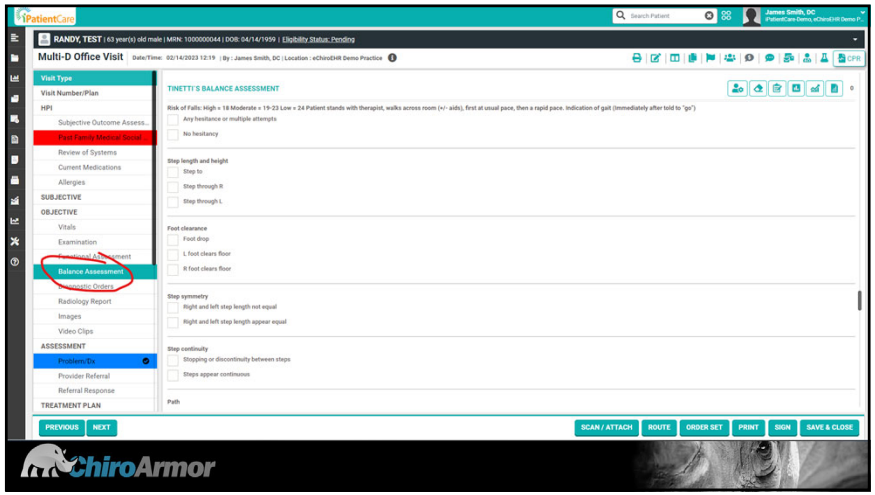
251

97112

Therapeutic procedure	97112 Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	Breaking down the description from an outcome perspective, there must be a neuromuscular problem requiring skilled intervention to permit the patient to sit or stand.

252



253

Balance Assessments

ACTIVITIES-SPECIFIC BALANCE CONFIDENCE ASSESSMENT
FALL SCREENING-BALANCE ERROR SCORING
FALL RISK ASSESSMENT (FRAT)
TINETTI`S BALANCE ASSESSMENT
BERG BALANCE TESTS
30 SECOND CHAIR STAND TEST
TIMED UP AND GO
SINGLE LIMB STANCE TEST

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254

Common Documentation Error

97112 not supported due to lack of establishing specific neurological parameters, specific neurological activities addressing neurological condition, time, reps/sets performed, by whom it was performed by

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Falls Risk

Screening and Plan of Care

256

256

Therapeutic Activities

The patient engages in dynamic, functional tasks such as throwing a ball, pushing a cart, or even activities like cooking. The fact that they are **functional movements** is a significant difference between therapeutic exercises and therapeutic activities: the latter are designed to **model real-life movements**, the former are merely supposed to help the patient make progress in a single parameter.

257

Reporting Therapeutic Activities

Therapeutic activities (97530 *Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes*) use functional activities (e.g., bending, lifting, carrying, reaching, catching, and overhead activities) to improve functional performance in a progressive manner.

The activities are usually directed at a loss or restriction of mobility, strength, balance, or coordination. They require the professional skills of a provider and are designed to address a specific functional need of the patient.

These dynamic activities must be part of an active treatment plan and directed at a specific outcome.

An example of 97530 might be to increase flexibility of the quadratus lumborum muscles while activating and stretching the hamstring muscles to improve the patient's capacity for walking and standing.

258

258

Report a gymnastic ball (a technique of performing lumbar stabilization exercise in some cases) used to cause multiple therapeutic changes with 97530.

Selecting the right code is dependent on the therapy's intended outcome for the exercise.

97530

259

97530

Therapeutic activities

CPT® 97530 Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes:

Dynamic activities include the use of multiple parameters, such as balance, strength, and range of motion, for a functional activity. Examples include lifting stations, closed kinetic chain activity, hand assembly activity, transfers (chair to bed, lying to sitting, etc), and throwing, catching, or swinging: Functional activities specifically related to work (hardening/conditioning) should be coded using 97545.

260

260

Common Documentation Error

97530 not supported due to lack of establishing parameters, specific activity addressed (-ing), time, reps/sets performed, by whom it was performed by

261

Contact the Payer for their requirements regarding use of -59 modifier for 97110-97124 codes.

97140 rule remains: If the 97140 is performed on the same region the same day, then not only will the carrier not reimburse for both procedures but the provider cannot bill the patient for both procedures either.

9894X with 97112 - 97124, 97140

262

Self-care/Home Management Training

97535

263

Self-Care/Home Management Training

The overall goal should be to get the patient to return to the highest level of function realistically attainable and within the context of the presenting problem. The plan of treatment should address specific therapeutic goals for which modalities and procedures are outlined in terms of type, frequency, and duration. There must be an expectation the condition will improve significantly in a reasonable and generally predictable time period, based on the assessment of the patient's rehabilitation potential.

264

Therapeutic Procedures, group (2 or more)

97150

265

265

Group vs. Individual Therapy Billing

For example: In a 25-minute period, a DC works with two patients, A and B. The DC moves back and forth between the two patients, spending a minute or two at a time with each, providing occasional assistance and modifications to patient A's exercise program and offering verbal cues for patient B's balance activities.

The proper coding for both patients is 97150. Documentation should identify the specific treatment technique(s) used in the group, how the treatment technique will restore function, the frequency and duration of the particular group setting, the number of persons in the group, and the treatment goal in the individualized plan.

266

266

Same-day Billing

Billing for both individual (one-on-one) and group services provided to the same patient on the same day is allowed, if the rules for one-on-one and group therapy are both met.

267

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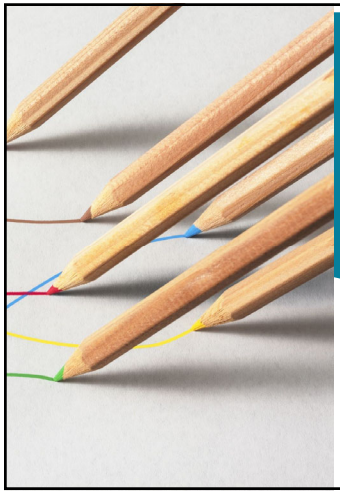

Multiple Units

268

268

The expectation is that a provider's direct patient contact time for each unit will average 15 minutes in length.

269

Example No. 1

- 8 minutes of therapeutic exercise (97110)
- 8 minutes of manual therapy (97140)
- TOTAL = 16 timed minutes
- What is the appropriate code/unit(s) to be billed?

270

270

Time-based Therapy Codes

1 unit	=	8-22 minutes
2 units	=	23-37 minutes
3 units	=	38-52 minutes
4 units	=	53-67 minutes

If a service represented by a 15-minute timed code is performed in a single day for at least 15 minutes, bill at least one unit. If the service is performed for at least 30 minutes, bill at least two units, etc.

271

Example No. 1

- 8 minutes of therapeutic exercise (97110)
- 8 minutes of manual therapy (97140)
- TOTAL = 16 timed minutes
- The appropriate billing in this example is one unit. You should select 97110 or 97140 to bill because each unit was performed for the same amount of time and only one unit is allowed.

272

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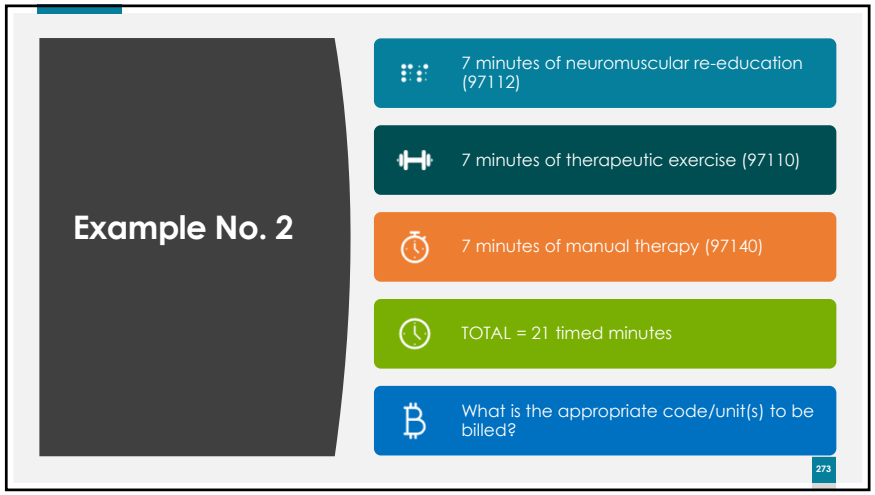

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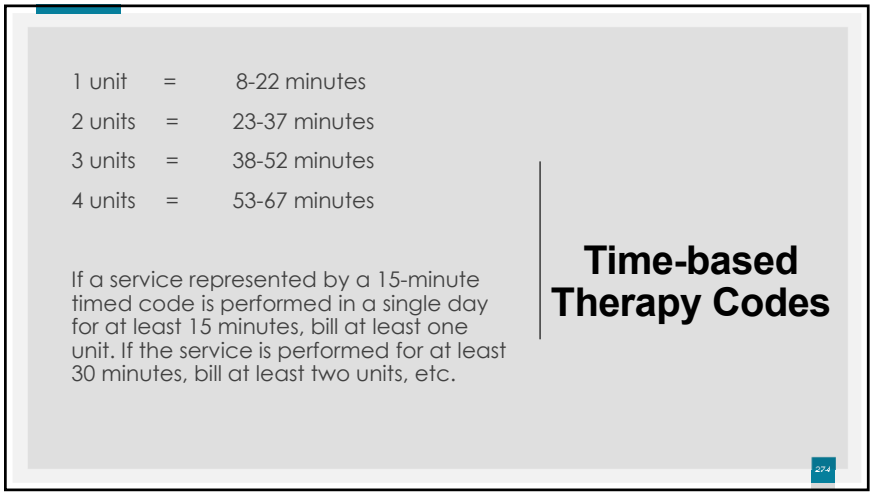

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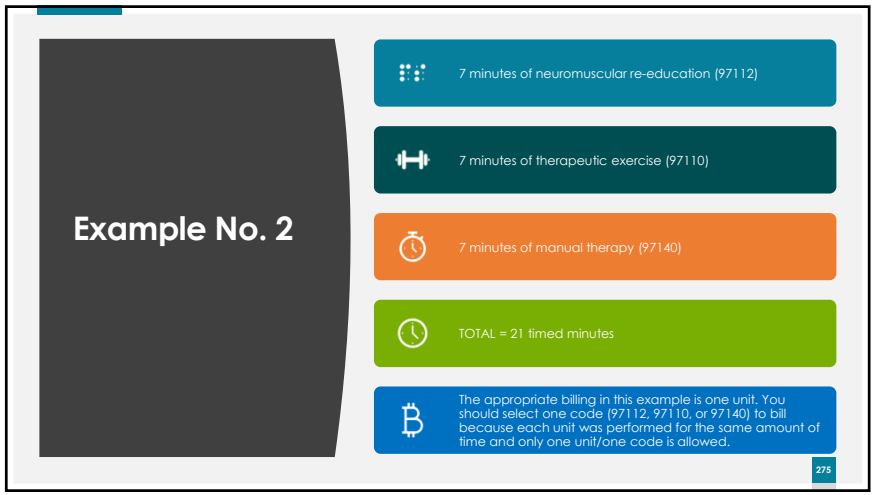

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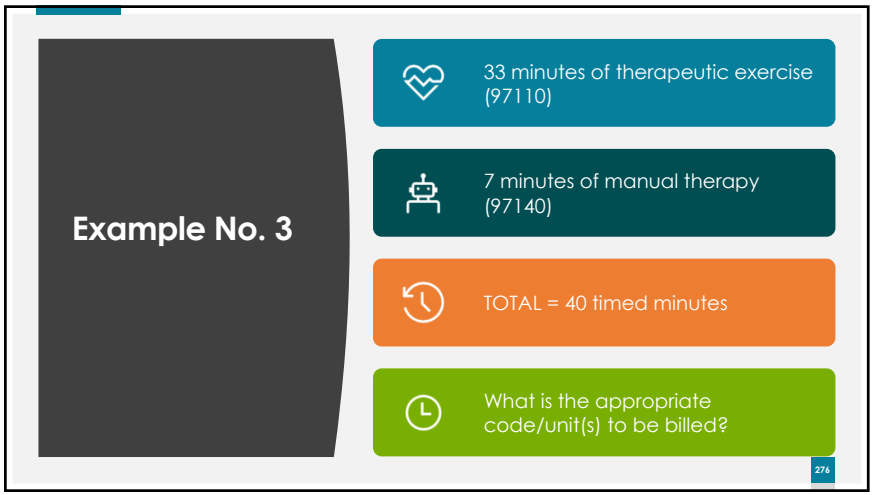

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1 unit = 8-22 minutes
2 units = 23-37 minutes
3 units = 38-52 minutes
4 units = 53-67 minutes

If a service represented by a 15-minute timed code is performed in a single day for at least 15 minutes, bill at least one unit. If the service is performed for at least 30 minutes, bill at least two units, etc.

Time-based Therapy Codes

277

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Example No. 3

- 33 minutes of therapeutic exercise (97110)
- 7 minutes of manual therapy (97140)
- TOTAL = 40 timed minutes
- The appropriate billing in this example is three units. Bill two units of 97110 and one unit of 97140, and count the first 30 minutes of 97110 as two full units.

278

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Example No. 4

- 24 minutes of manual therapy (97140)
- 23 minutes of therapeutic exercise (97110)
- TOTAL = 47 timed minutes
- What is the appropriate code/unit(s) to be billed?

279

279

1 unit = 8-22 minutes
2 units = 23-37 minutes
3 units = 38-52 minutes
4 units = 53-67 minutes

If a service represented by a 15-minute timed code is performed in a single day for at least 15 minutes, bill at least one unit. If the service is performed for at least 30 minutes, bill at least two units, etc.

Time-based Therapy Codes

280

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Example No. 4

- 24 minutes of manual therapy (97140)
- 23 minutes of therapeutic exercise (97110)
- TOTAL = 47 timed minutes
- The appropriate billing in this example is three units. Each service is performed for more than 15 minutes, so bill each for at least one unit. The correct way to code this example is two units of 97140 and one unit of 97110, **assigning more timed units to the service that took the most time.**

281

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Example No. 5

- 18 minutes of therapeutic exercise (97110)
- 13 minutes of manual therapy (97140)
- 10 minutes of therapeutic activities (97530)
- 8 minutes of ultrasound (97035)
- TOTAL = 49 timed minutes
- What is the appropriate code/unit(s) to be billed?

282

282

Time-based Therapy Codes

1 unit	=	8-22 minutes
2 units	=	23-37 minutes
3 units	=	38-52 minutes
4 units	=	53-67 minutes

If a service represented by a 15-minute timed code is performed in a single day for at least 15 minutes, bill at least one unit. If the service is performed for at least 30 minutes, bill at least two units, etc.

283

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Example No. 5

- 18 minutes of therapeutic exercise (97110)
- 13 minutes of manual therapy (97140)
- 10 minutes of therapeutic activities (97530)
- 8 minutes of ultrasound (97035)
- TOTAL = 49 timed minutes
- The appropriate billing in this example is three units. **You should bill the procedures you spent the most time providing.**

284

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Therapeutic procedures and modalities are not covered by insurance when the documentation indicates the patient has attained the therapy goals or has reached the point where no further significant practical improvement can be expected.

Source: Medicare Benefits Policy Manual, section 220 – Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance."

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Subsequent Visit Note Audit Checklist

SUBJECTIVE (per Chief Complaint Region)	YES	NO
Pain Intensity and Quality Noted and Updated?		
Specific ADL limitations Noted and Updated?		
Changes Since Last Visit Noted and Updated?		
OBJECTIVE (per Chief Complaint Region)	**YES**	**NO**
Objective Findings Noted?		
Problem/DX Assigned?		
Procedure Detail Documented?		
Patient Instruction/Education Documented?		
ASSESSMENT	**YES**	**NO**
Any updates to clinical decision making?		
CMT (9894X) or Manual Therapy (97140)	**YES**	**NO**
Performed By (with credentials) Completed?		
Location Documented?		
Time Documented?		
Rehab, Therapeutic Modalities	**YES**	**NO**
Performed By (with credentials) Completed?		
Parameters Established?		
Technique Applied Documented?		
Regions Addressed?		
Time Documented?		
Patient Instruction/Education Documented?		
CHARGE CAPTURE	**YES**	**NO**
Problem/DX Assigned?		
CPT Codes Extracted?		
Do the CPT Codes Correlate with the ICD Codes?		
CPT/ICD Codes Linked?		

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Most Common Documentation Errors Recap

Treatment Plan not completed correctly
Lack of documenting changes since the last visit
Default documentation
Improper coding
Lack of correct documentation per code requirements
Lack of completing notes in timely manner

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Progress Evaluations

Discharge from care when goals have been achieved.

288

Compare previous history and examination findings

Re-assess patient's progress towards goals and treatment plan

Update the patient on progress with a report of findings

Progress Evaluations

289

289

Document Progress against the Goals

Progress Evaluations every 12 visits or 30 days

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Discharge from Care:

Have the goals been achieved for the episode of care?

OR

Has the patient reached a plateau in therapeutic gains and/or human performance?

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Aggravation vs. Exacerbation

What's the difference?

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When an injury or incident creates, worsens, or combines with a preexisting condition to create a new and greater disability.

Aggravation

https://definitions.uslegal.com/a/aggravation-rule/

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An increase in the severity of a disease or its signs or symptoms; a natural progression of the condition. (throwing gas on a fire)

Exacerbation

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Co-Management, Consult, and Referrals

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Co-Management, Consult, and Referral Scenarios

Single Visit Consultation: A clinician decides a patient may need to seek another opinion. The referral clinician consults and evaluates the patient and then reports back to the patient and referring clinician the results of the visit.

Co-Management with Shared Care: This results when both the referring and referral clinicians decide there is benefit for the patient to combine their care plan and management, sharing the management of the patient by overseeing the scope of their treatment for the patient; but with communication between both clinicians regarding status of each care plan and response.

Co-Management with Principal Care: One of the clinicians involved becomes the captain of the team-based care model and is assigned the primary responsibility for the patient. The captain directs the care plan, involving other clinicians and providers in the process and delivery of care.

Transition of Care (for whole-person care): A clinician becomes responsible for the patient's whole care when a referral is made, transitioning the full responsibility of care to the referral clinician.

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1. Single Visit Consultation
2. Co-Management with Shared Care
3. Co-Management with Principal Care
4. Transition of Care for whole-person care
5. Communication of results to patient/family/caregiver

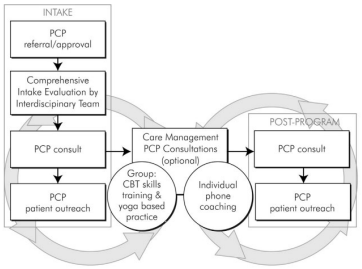

Fig. 2. PPACT intervention description.

https://www.contemporaryclinicaltrials.com/article/S1551-7144(17)30578-5/pdf

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1. Know who you need to work with on the care team.

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2. Determine what services you want the consult/referral provider to perform.

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3. Organize your clinical data logically in a consult/referral letter.

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4. Document your referral in the patient's chart

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301

5. Track the referral to close the loop.

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Tracking the Consult or Referral and Closing the Loop

- **Clinical Summary** or reason for the consult and/or referral
- Provider(s) involved will agree to the **appropriate care plan approach and what role(s) each will play**
- **Timely communication** regarding the progress
- **Enters the dates and referral report results** into the patient's EHR

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Signature

- **Big Deal to Medicare**
  - ✓ Medicare requires a signature that is either handwritten or electronic. NO stamps
- **Signature Log**
  - ✓ If your signature is poor, then include a Signature Log when submitting any requested documentation.
- **Signature Attestation**
  - ✓ Providers can submit an attestation form if required.

304

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All covered services (payable or non-payable) provided to a Medicare patient must be billed to Medicare.

Your patient has the option to determine if non-payable and/or non-covered services may be billed to Medicare by completing the ABN.

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Patient Non-Compliance

The question to ask is this: Is the patient being non-compliant because they don't agree or value the care, or is it because their diagnosis and treatment plan was not explained to them very well by the doctor?

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Self-directed care is considered Maintenance Therapy

ABN must be provided

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MAINTENANCE THERAPY

Medicare policy defines maintenance therapy as a "treatment plan that seeks to **prevent disease, promote health, and prolong and enhance the quality of life**; or therapy that is performed to **maintain or prevent deterioration of a chronic condition**.

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**."

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MAINTENANCE THERAPY

The AT modifier must not be placed on the claim when maintenance therapy has been provided.

Claims without the AT modifier will be considered as maintenance therapy.

Chiropractors who give or receive an Advance Beneficiary Notice (ABN) from a beneficiary shall follow the instructions in the Medicare Claims Processing Manual.

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21-23

https://www.menti.com/al279xf862ga

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ABN Modifiers

- AT: (Active Treatment) When you provide acute or chronic active treatment to Medicare beneficiaries, you must add the AT modifier. Only used for 98940, 98941, 98942
- GP: Provided an ABN when statutorily excluded services delivered under an outpatient physical therapy plan of care. Examples include: G0283-Electric Stimulation, 97035 Ultrasound, 97024 Diathermy, 97140 Manual Therapy, 97110 Therapeutic Exercises, 97112 Neuromuscular Re-Ed, 97530 Therapeutic Activities, etc.
- GA: Provided the ABN identifying a service that will be denied as not medically necessary
- GX: Service excluded by statue and ABN given on a voluntary basis. DO NOT use this modifier with any other modifier, including the AT modifier.
- GY: Item or service statutorily excluded, does not meet the definition of any Medicare benefit. Provided the ABN identifying a service that will be denied as not medically necessary. May use this modifier in combination with modifier GX.
- GX: Notice of liability issued, voluntary under payer policy. Service excluded by statute and ABN given on a voluntary basis. Report when you issue a voluntary ABN for a service Medicare never covers because it is statutorily excluded or is not a Medicare benefit. May use this modifier in combination with modifier GY.
- GZ: Did not provide the ABN when service anticipated denied based on medical necessity. Item or service expected to be denied as not reasonable and necessary. Report when you expect Medicare to deny payment of the item or service due to a lack of medical necessity and no ABN was issued.

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The ABN must:

- Be in writing.
- Identify the specific service that may be denied (CPT code should be recommended).
- State the specific reason why the physician believes that service may be denied.
- Be signed by the patient acknowledging that the required information was provided, and that the patient assumes responsibility.
- Indicate ABN is billed with an AT-GA modifier on the date the waiver is signed during a service that may be medically necessary but needs to be determined by Medicare.
- Indicate the CMT is billed only with a GA modifier on the date the waiver is signed during a non-medically necessary setting.

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Any ABN (waiver) will not be accepted if the:

- The patient is asked to sign a blank form.
- ABN is used routinely without regard to particularized need.
- The Medicare approved waiver is not the actual waiver signed by the patient.
- Approved waiver has been altered beyond what is allowed by CMS.

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ABN and Diagnostic Testing/Excluded Services

"Practice Name service that includes x-rays, exams, and therapies are considered a non-covered service under national coverage rules."

This statement on ABN would inform the patient that the provider is to be paid for all excluded services by the patient.

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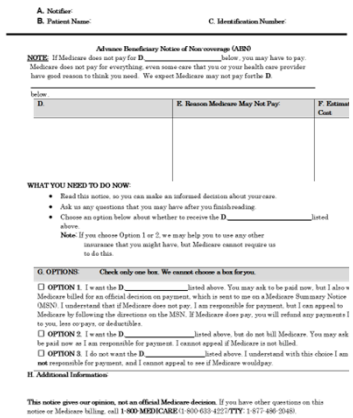
ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e., care that is never covered) or fails to meet a technical benefit requirement (i.e., lacks required certification). However, the ABN can be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered.



A. Notifier:
B. Patient Name:
C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare does not pay for **D**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D**.

below.

D	E. Reason Medicare May Not Pay:	F. Estimat Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

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

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

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

☐ **OPTION 3.** I do not want the **D**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

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Amendment of a Patient Note

- Date and Time Stamped
- Amendment made
- Reason for Amendment documented
- Electronically Signed/Date and Time Stamped

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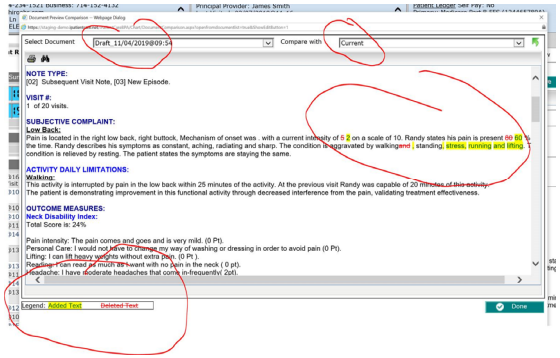

Note Amendment: Tracking Changes

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What happens when the patient's progress reaches a plateau?

Chronic Pain Management begins…

Clinical Practice Guideline: Chiropractic Care for Low Back Pain Globe, Gary et al. Journal of Manipulative & Physiological Therapeutics, Volume 39, Issue 1, 1 - 22

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Chronic Prognostic Factors

- ✓ Older age (pain and disability)
- ✓ History of prior episodes (pain, activity limitation, disability)
- ✓ Duration of current episode >1 month (activity limitation, disability)
- ✓ Leg pain [for patients having LBP] (pain, activity limitation, disability)
- ✓ Psychosocial factors [depression (pain); high fear-avoidance beliefs, poor coping 354 skills (activity limitation); expectations of recovery]
- ✓ High pain intensity (activity limitation; disability)
- ✓ Occupational factors [higher job physical or psychological demands (disability)]
- ✓ Other factors or comorbidities not listed above may adversely affect a given patient's prognosis and management.

Document in the clinical record!

319

319

Factors which may lead to complicating the recovery time…

- ✓ **Nature of employment/work activities or ergonomics** The nature and psychosocial aspects of a patient's employment must be considered when evaluating the need for ongoing care (e.g., prolonged standing posture, high loads, and extended muscle activity).
- ✓ **Impairment/disability** The patient who has reached MTB but has failed to reach pre-injury status has an impairment/disability even if the injured patient has not yet received a permanent impairment/disability award.
- ✓ **Concurrent condition(s)** and/or use of certain medications may affect outcomes.
- ✓ **History of prior treatment** Initial and subsequent care (type and duration), as well as patient compliance and response to care, can assist the physician in developing appropriate treatment planning. Delays in the initiation of appropriate care may complicate the patient's condition and extend recovery time.
- ✓ **Lifestyle habits** Lifestyle habits may impact the magnitude of treatment response, including outcomes at MTB.
- ✓ **Psychological factors** A history of depression, anxiety, somatoform disorder or other psychopathology may complicate treatment and/or recovery.

Document in the clinical record!

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Chronic Pain Management Checklist

- Patient preferences and functional/lifestyle goals.
- Treatment goals.
- Assessment of potential barriers to meeting goals.
- Strategies for addressing potential barriers to meeting goals.
- Care team members, including the PCP of record and team members.
- A self-care plan with written instructions.

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Trial of therapeutic withdrawal may begin…

Patient may be released on a PRN basis with instructions on self-care management and/or reduced in frequency of care and monitored for regression of condition over a six months timeframe.

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Chronic Pain Management Strategy

Those patients with chronic pain may vary in their need for intervention. Self-care management is a foundational element in their care plan. Chronic pain management may be:

1. Self-care management only
2. Active treatment for aggravations or exacerbations leading to episodic care
3. Ongoing "scheduled" care for those chronic pain sufferers who have a predictable need for care prescribed at specific times validated through a trial of withdrawal that demonstrated **regression of their condition**.

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Regression of the Condition

When pain and/or ADL dysfunction exceeds the patient's ability to self-manage, the medical necessity of care should be documented, and the chronic care treatment plan altered appropriately.

Clinical Practice Guideline: Chiropractic Care for Low Back Pain Globe, Gary et al. Journal of Manipulative & Physiological Therapeutics, Volume 39, Issue 1, 1 - 22

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Key clinical questions for care plan decision making…

Can the patient manage through the regression on his/her own?

Will the condition need episodic care to bring back MTB?

Has the condition deteriorated enough that normal daily activities cause regression of the maximum therapeutic benefit over time – necessitating prescribed and timely ongoing care?

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Final Evaluation
(Six months or prior)

Following the six months trial of therapeutic withdrawal the patient returns for a final evaluation to verify if a maximum therapeutic benefit has been sustained.

The findings of the evaluation will determine course of management including self-management or the need for future chiropractic care (episodic or ongoing) to retain the benefits achieved; if regression of the condition has been confirmed.

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Chronic Care Management Plan

Preventing relapse and/or exacerbations of the original complaint(s) as well as associated comorbidities thereby sustaining the patient's maximum therapeutic benefit.

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Chronic Care Management Plan

- Patient specific goals:
  - Consisting of the pain, activity, range of motion goals which have been previously determined as the benchmark of the maximum therapeutic benefit for the patient's condition.
- Frequency and Duration of care:
  - Dependent upon whether the care is episodic or ongoing.
    - If episodic care is required, then the frequency and duration will be conducted through a trial of care.
    - If the care is ongoing, then the frequency determined to be necessary is based upon the regression experience from therapeutic withdrawal which will inform the treatment prescription.

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Chronic Pain Management
Checklist

- ✓Patient preferences and functional/lifestyle goals.
- ✓Treatment goals.
- ✓Assessment of potential barriers to meeting goals.
- ✓Strategies for addressing potential barriers to meeting goals.
- ✓Care team members, including the PCP of record and team members beyond the referring or transitioning provider and the receiving provider.
- ✓A self-care plan with written instructions.

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Overall Goal

The overall goal of treatment is an emphasis on improving function through the development of long-term self-management skills including fitness and a healthy lifestyle in the face of pain that may persist.

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Algorithms for Spine-related Pain

Algorithms for the Chiropractic Management of Acute and Chronic Spine-Related Pain

Clinical Practice Guideline: Chiropractic Care for Low Back Pain. Gary Globe, PhD, MBA, DC, Ronald J. Farabaugh, DC, Cheryl Hawk, DC, PhD, Craig E. Morris, DC, Greg Baker, DC, Wayne M. Whalen, DC, Sheryl Walters, MLS, Martha Kaeser, DC, MA, Mark Dehen, DC, Thomas Augat, DC. Journal of Manipulative & Physiological Therapeutics. Volume 39, Issue 1, Pages 1-22 (January 2016) DOI: 10.1016/j.jmpt.2015.10.006

https://pubmed.ncbi.nlm.nih.gov/26804581/

331

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Treatment Frequency and Duration

- Frequency and duration of treatment may be influenced by individual patient factors or characteristics that present as barriers to recovery (e.g. comorbidities, clinical yellow flags).
- The therapeutic effects of chiropractic treatment should be evaluated by subjective and/or objective assessments after each course of treatment.

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Patients responsive to the initial two week trial:

Treatment frequency will be reduced gradually while being moved toward more active and preventative approaches including:

1. Instruction in activities of daily living

2. Exercises and stretching based on clinical status of the patient

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Patients unresponsive to an initial two-week trial:

- Will be re-evaluated and (if there are no concerns of serious pathology) managed using a different chiropractic treatment approach
- If the patient is responsive to care, he/she will progress to more active forms of care as listed above.

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Patients who are unresponsive after one month

May require special imaging or special studies to determine the possible underlying cause or the patient may be referred for a second chiropractic opinion or medical opinion.

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Chronic Pain

- Chronic pain is considered the most underestimated health care problem impacting quality of life.
- Today, chronic pain is one of the most common reasons for patients to seek medical care; it is estimated that 35% of the US population in general, 25% of children younger than 18 years, and 50% of community-dwelling older adults experience chronic pain.
- The majority of chronic pain is spine-related

CHIROPRACTIC CLINICAL COMPASS

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PHARMACOLOGICAL MANAGEMENT AND ASSOCIATED COSTS

- Frequent use of opioids in managing chronic non-cancer pain has been a major issue for health care in the United States, with significant concerns related to adverse effects, misuse, abuse and addiction.
- While these medications serve as powerful pain killers, they have also been implicated for potential drug abuse.

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Definition of "Chronic Pain Patients"

- Chronic pain patients are those for whom ongoing supervised treatment/care has demonstrated clinically meaningful improvement with a course of management and have reached MTI, but in whom significant residual deficits in activity performance remain or recur upon withdrawal of treatment.
- The management for chronic pain patients ranges from home-directed self-care to episodic care to scheduled ongoing care.

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Definition of "Chronic Pain Patients"

- Patients who require provider-assisted ongoing care are those for whom self-care measures, while necessary, are not sufficient to sustain previously achieved therapeutic gain.
- These patients may be expected to progressively deteriorate as demonstrated by previous treatment withdrawals.

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Application of Chronic Pain Management

- Chronic pain management occurs after the appropriate application of active and passive care including lifestyle modifications.
- It may be appropriate when rehabilitative and/or functional restorative and other care options, such as psychosocial issues, home-based self-care and lifestyle modifications, have been considered and/or attempted, yet treatment fails to sustain prior therapeutic gains and withdrawal/reduction results in the exacerbation of the patient's condition and/or adversely affects their activities of daily living (ADLs).

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Document the necessity of ongoing care for chronic conditions…

- Severity of symptoms and objective findings
- Patient compliance and/or non-compliance factors
- Factors related to age
- Severity of initial mechanism of injury
- Number of previous injuries (>3 episodes)
- Number and/or severity of exacerbations
- Psycho-social factors (pre-existing or arising during care)
- Pre-existing pathology or surgical alteration
- Waiting >7 days before seeking some form of treatment
- Ongoing symptoms despite prior treatment
- Nature of employment / work activities or ergonomics
- History of lost time
- History of prior treatment
- Lifestyle habits
- Congenital anomalies
- Treatment withdrawal fails to sustain MTI

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Chronic Care General Goal Category Considerations

- Minimize lost time on the job
- Support patient's current level of function/ADL
- Pain control/relief to tolerance
- Minimize further disability
- Minimize exacerbation frequency and severity
- Maximize patient satisfaction
- Reduce and/or minimize reliance on medication

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Patient Engagement

Opportunities for Education

Report of findings following initial examination, re-evaluations, and relevant patient visits

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Report of Findings
collaborative conversation

Report of Findings includes:

a. diagnosis,

b. recommended treatment plan,

c. individualized patient goals, potential barriers, self care abilities,

d. written instructions for self care,

e. Education, resources for treatment and self care

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Report of Findings

- You are not selling the patient on care. You are a clinician delivering the facts.
- You are to be friendly, but you are not there to be their friend. Stay unbiased and objective.
- Report to the patient within the context of tissue involvement and healing response times. (i.e., muscle 2-4 weeks, bone 6-8 weeks, ligament 6-12 weeks, disc 12-24 weeks)
- Narrow it down for the patient. Keep it simple. Facilitate meaningful discussion leading to a decision.
- Correlate the report of findings with the financial plan (staff driven)

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Questions or Comments?

Thank you!!

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Scott Munsterman, DC, FICC, CPCO

Brief Bio

Dr. Scott Munsterman is an acknowledged expert on the transforming model of health care delivery and compliance with a commitment to the promotion and advancement of the chiropractic profession. Dr. Munsterman is founder and CEO of Best Practices Academy, a clinical improvement organization providing focused leadership to bring practices into compliance with regulatory standards, equip them to improve clinical outcomes, and integrate into the transformed care delivery system. Dr. Scott works with ChiroArmor and eChiroEHR.

Dr. Munsterman is a graduate of Northwestern Health Sciences University, where he has served as Vice-Chair of the Board of Trustees and on the President's Cabinet as Chief of Care Delivery. He was awarded Chiropractor of the Year in South Dakota and the Fellow of the International College of Chiropractors (FICC). He is a professional compliance officer. Dr. Munsterman served two terms as Mayor of the City of Brookings and three consecutive terms in the South Dakota House of Representatives, where he chaired the House Health and Human Services Committee and also chaired the Legislative Planning Committee. He is author of the books "A Vision for South Dakota", "Care Delivery and Chiropractic: An Opportunity Waiting", and "Unfinished Business".

However, he states his greatest accomplishment has been his five daughters and six grandchildren - with more success to come.

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Professionalism

What does this mean?
What are my responsibilities?
How does a career in health care impact my personal life?

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Clinical Conscientiousness

Developing and maintaining a clinical mindset

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Clinical Awareness

A constant, ongoing process throughout the day…

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Communication

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What is Patient Safety?

First do no harm.

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Patient safety: the avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of health care.

National Patient Safety Foundation. Agenda for research and development in patient safety.
http://www.ihi.org/Topics/PatientSafety/Pages/default.aspx

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What is an Adverse Outcome or Event?

An unexpected and undesired incident directly associated with the care or services provided to the patient; an incident that occurs during the process of providing health care and results in patient injury or death; or an adverse outcome for a patient, including an injury or complication.

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Preventing Clinical Errors

An act of omission or commission in planning or execution that contributes or could contribute to an unintended result.

Defining medical error. Ethan D. Grober, John M.A. Bohnen Can J Surg. 2005 Feb; 48(1): 39–44. PMCID: PMC3211566
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3211566/

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Preventable Harm

The Institute for Healthcare Improvement defines preventable medical harm as "unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment), that requires additional monitoring, treatment or hospitalization, or that results in death."

These mistakes, called "preventable harm" or "adverse events" in medical literature, account for up to 1,000 deaths per day.

https://costsofcare.org/tallying-the-high-cost-of-preventable-harm/

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Causes of Errors

Adverse Events vs Near Misses

Human vs System

Commission vs Omission

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How can we address patient safety in our practice?

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Screening Patients

Monitor changes since the last visit

No change or worsening

Observation of patient's behaviors and characteristics

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Has there been a "Significant Event"?

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Does the patient's clinical presentation require urgent need for evaluation and/or care?

The doctor must be informed of any new information about the patient that has been related to staff.

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Stay Connected to Established Patients who are under a treatment plan.

Following the treatment plan, evidence-informed care guidelines, and the patient's response to care...

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Patient Safety is First and Foremost

There should be an ongoing discussion regarding strategy towards preventing clinical errors and enhancing patient safety.

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Most interactions are the result of many causes and predisposing conditions.

In other words, there are a variety of factors involved that can lead to or cause a clinical error or adverse event – or a near miss.

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Swiss Cheese Model

Reason J. Human error: Models and management. BMJ 2000; 320:768-70

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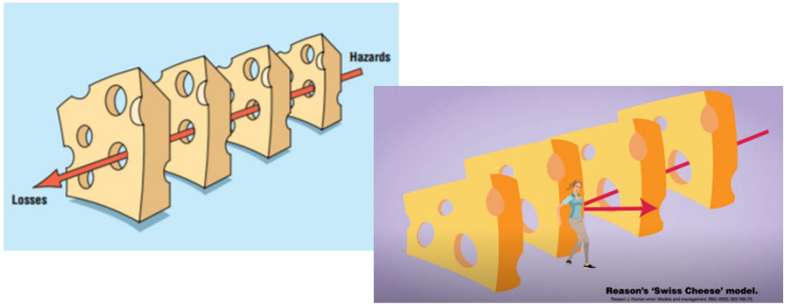
https://www.youtube.com/watch?v=7YlIHupZ2e0&feature=youtu.be

It just takes one thing to block the incident…



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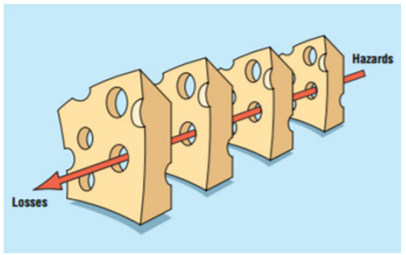
Holes in the Defense Layers

A bad outcome occurs only when the holes in many defense layers momentarily line up to permit a trajectory of an accident opportunity—bringing hazards into damaging contact with patients.



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Reasons for Holes in the Defense Layers

Active Failures are the unsafe acts committed by people who are in direct contact with the patient or system. They take a variety of forms: slips, lapses, fumbles, mistakes, and procedural violations.

Latent Conditions have two kinds of adverse effects:

- they can translate into error provoking conditions within the workplace (i.e. time pressure, understaffing, inadequate equipment, fatigue, inexperience) and
- they can create long-lasting holes or weaknesses in the defenses (i.e. lack of training for staff, improper therapeutic or billing practices, lack of compliance policy).

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But when incidents do occur…

- The incident should not be kept secret. All incidents need to be documented and discussed with the doctor and coworkers.
- The doctor should talk to the patient
  - Discuss what has been learned
  - Provide an honest expression of regret or apology
  - Can often decrease the risk of legal action

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What are the defense layers in the practice?

1. Emergency identification/response procedures are in place.
2. Performing vital signs.
3. Properly diagnosis a patient's condition.
4. Identifying contraindications for care and red flags.
5. Perform manipulation procedure properly.
6. Safely apply therapeutic procedures/activities on each visit.
7. Close oversight/response of patient monitoring during care.
8. Close oversight of visitors/children during patient's visit.
9. Awareness of external activities within and outside of the facility.
10. Doctor/Staff rested and devote 100% present time consciousness.

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Most Common Patient Safety Issues

- Falls
- Equipment malfunction
- Infection prevention procedures
- Faulty patient perception of an incident occurring stemming from lack of communicating to the patient what to expect from treatment
- Underlying medical emergency/red flag (i.e., cardiovascular, cerebrovascular, fracture, infection, cancer)

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Recognizing Patient Safety Incidents

- Patient complains of pain after treatment
- Modality malfunctioning or not being applied properly
- Patient nearly falling
- Patient safety incidents range from "No Harm" to "Unnecessary Harm"

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Underlying Causes

- Patient OTC drug use and interactions increase risk of falls
- Provider/therapist fatigue and stress can lead to miscommunications
- Short staffing and increased workload

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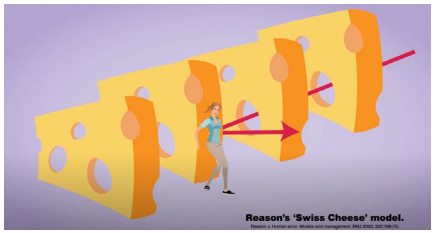
Follow Safe Practice Procedures

You and your staff must be the "**one thing**"…



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Scope of Safety Issues

In Chiropractic…

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Professional boundaries are limits which protect a worker's professional power and their patient's vulnerability. Successful and ethical working relationships are based on a clear understanding of what the workers' role is – and just as importantly – what their role isn't.

Definition of Professional Boundary

https://mcarthur.com.au/media/1429/understanding-professional-boundaries.pdf

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Professional Boundaries in Clinical Practice

Patient Relationships

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When does Clinical Integrity become compromised?

THE ROLE	THE LINE	THE IMPACT
Professional Service Social Interaction		
Mutual Friendship	BOUNDARY CROSSING	CONSCIENTIOUSNESS OF BOUNDARY VIOLATION PENDING
Close Friendship Family Intimacy	BOUNDARY VIOLATION	PERSONAL GAIN EMOTIONAL DEPENDENCY VIEWED AS EXPLOITATION IF PROFESSIONAL ROLE IS CONTINUED

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What is our role as a health care professional?

- Perform clinical duties and provide care to a patient
- Protect the patient from harm
- Meet reasonable expectations of the patient
  - Respect and dignity
  - Provide competent care
  - Practice ethically
  - Uphold confidentiality
  - Comply with all laws regulating your practice and behaviors
- Honesty in all patient interactions
- Equitable and fair treatment of all patients regardless of their race, religion, socioeconomic status, etc.

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Has your allegiance shifted away from your focus in your professional role to a more personal role whereby you are seeking and benefiting personally from the relationship?

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Commonly Misdiagnosed Conditions

The "Big Three": misdiagnosed cancers (37.8%), vascular events, like stroke and heart attack (22.8%), and infections (13.5%).

Cancers

Lung, breast, colorectal, prostate, and skin cancers

Vascular events

Stroke, heart attack, venous thromboembolism (blood clots in the legs and lungs), aortic aneurysm and rupture (dissection), arterial thromboembolism (a blockage of the blood supply to internal organs)

Infections

Sepsis, meningitis, encephalitis, spinal infection, pneumonia, and endocarditis (a heart infection)

Newman-Toker, D. E., Schaffer, A. C., Yu-Moe, C., Nassery, N., Saber Tehrani, A. S., Clemens, G. D., Wang, Z., Zhu, Y., Fanai, M., & Siegal, D. (2019). Serious misdiagnosis-related harms in malpractice claims: The "Big Three" – vascular events, infections, and cancers. *Diagnosis*, 6(3), 227-240. doi: https://doi.org/10.1515/dx-2019-0019

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What are the various factors that may set us up for risk of a clinical error in practice?

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Evaluation Process

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Intake Forms

Accurate information from the patient is imperative to gather for your doctor's clinical decision making.

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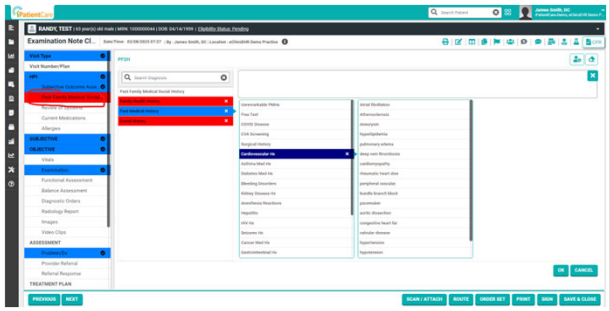
History of Present Illness

Past Family Medical Social History

Review of Systems

Chief Complaints



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- Prior Major Illnesses and Injuries
- Prior Surgeries
- Prior Hospitalizations
- Current Medications
- Allergies
- Age Appropriate Immunization Status

- Age Appropriate Feeding/Dietary Status
- Marital Status
- Current Employment
- Occupational History
- Alcohol and Tobacco Usage
- Level of Education
- Sexual History

- Ask if there are any members of the patient's family who have had illnesses with features similar to the patient's.
- Determine the health or cause of death of the patient's parents and siblings.
- Establish whether there is a history of heart disease, high blood pressure, cancer, tuberculosis, stroke, diabetes, arthritic conditions, thyroid disease, kidney disease, asthma, blood diseases, sexually transmitted diseases, or any familial diseases.

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1. Constitutional
2. Eyes
3. Ears, nose, mouth, throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/Lymphatic
14. Allergic/Immunologic

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CVA Screening

Has the patient reported any of the following risk factors or symptoms in the medical history?

Is there nausea, vomiting, sensory disturbances (hearing, visual), cramps, weakness, headache, dizziness, and/or loss of consciousness?

Risk Factors:

- Dizziness
- Unsteadiness
- Giddiness
- Vertigo
- Sudden severe pain in the side of the head and/or neck, which is different from any pain the patient has had before
- Age <45 years
- Migraine
- Connective Tissue Disease
- Recent infection (i.e. upper respiratory)

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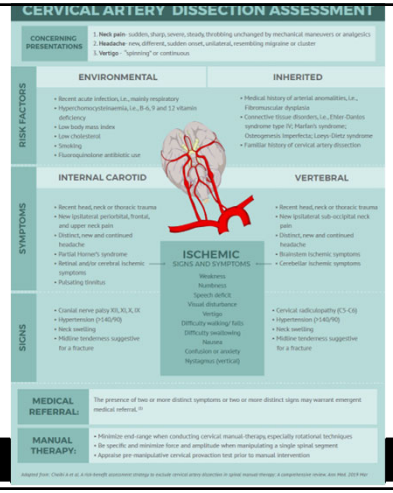

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What are Vital Signs?

These are measurements of the inner workings of the human body and how vital organs, such as the heart and lungs, are functioning.

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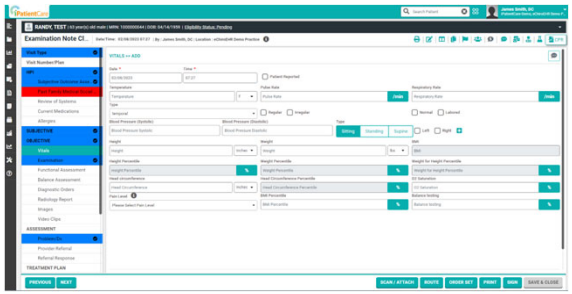
INITIAL/PROGRESS VISIT EXAMS

VITAL SIGNS

- HEIGHT
- WEIGHT
- BMI
- BLOOD PRESSURE
- HEART RATE
- RESPIRATION
- BODY TEMPERATURE



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- Height
- Weight
  - Abnormal weight loss or gain
  - Rapid change in height
- BMI (calculated from height/weight)
- Temperature
  - Signs of systemic infection or inflammation in the presence of a fever (temp > 101.4 F or sustained temp > 100.4 F. COVID-19 >100F).
- Respirations
  - Varies with age, normal reference range is 16-20 breaths/minute.
- Pulse
  - A newborn or infant can have a heart rate of about 130-150 beats per minute.
  - A toddler's heart will beat about 100-120 times per minute,
  - An older child's heartbeat is around 90-110 beats per minute, adolescents around 80-100 beats per minute, and
  - Adults pulse rate is anywhere between 50 and 80 beats per minute.

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- **Normal**

<120 Systolic<80 diastolic medication not needed, lifestyle recommendations

- **Pre-hypertensive**

120-139 systolic 80-89 diastolic, medication not needed, lifestyle modification (90% chance at 65 to develop stage 1 and stage 2, lifestyle changes will decrease risk to almost 0)

- **Stage 1 hypertension**

140-159 systolic or 90-99 diastolic, lifestyle modifications given, medications recommended starting with thiazide-type diuretics (consider others if ineffective)

- **Stage 2 hypertension**

>160 systolic or >100 diastolic, lifestyle modifications given, two-drug combination therapy recommended.

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Notes on Blood Pressure

- Maximum Cuff Pressure - When the baseline blood pressure is already known or hypertension is not suspected, it is acceptable in adults to inflate the cuff to 200 mmHg and go directly to auscultating the blood pressure. Be aware that there could be an **auscultory gap** (a silent interval between the true systolic and diastolic pressures).
- Bell or Diaphragm? - Even though the Korotkoff sounds are low frequency and should be heard better with the bell, it is often difficult to apply the bell properly in the anticubital fold. For this reason, it is common practice to use the diaphragm when taking blood pressure.
- Systolic Pressure - In situations where auscultation is not possible, you can determine systolic blood pressure by palpation alone. Deflate the cuff until you feel the radial or brachial pulse return. The pressure by auscultation would be approximately 10 mmHg higher. Record the pressure indicating it was taken by palpation (60/palp).
- Diastolic Pressure - If there is more than 10 mmHg difference between the muffling and the di

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Blood Pressure

- Higher blood pressures are normal during exertion or other stress. Systolic blood pressures below 80 may be a sign of serious illness or shock.
- Blood pressure should be taken in both arms on the first encounter. If there is more than 10 mmHg difference between the two arms, use the arm with the higher reading for subsequent measurements.
- It is frequently helpful to retake the blood pressure near the end of the visit. Earlier pressures may be higher due to the "white coat" effect.
- Always recheck "unexpected" blood pressures yourself.

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Pulse, or Heart rate, is the number of times a heart beats per minute (bpm). Heart rates vary by person, and a normal pulse can range between 60 to 100 beats per minute.

Pulse (Heart Rate)

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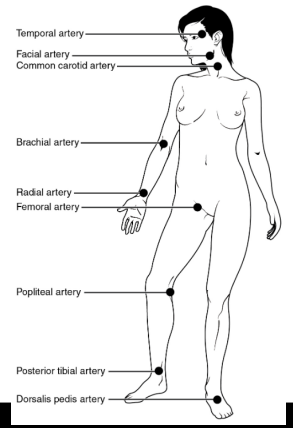
Pulse

Pulse

Pulse indicates heart rate and it is measured clinically to provide clues to a patient's state of health. It is recorded as beats per minute. Both the rate and the strength of the pulse are important clinically. A high or irregular pulse rate can be caused by physical activity or other temporary factors, but it may also indicate a heart condition.

The pulse strength indicates the strength of ventricular contraction and cardiac output. If the pulse is strong, then systolic pressure is high. If it is weak, systolic pressure has fallen, and medical intervention may be warranted.

Pulse can be palpated manually by placing the tips of the fingers across an artery that runs close to the body surface and pressing lightly. While this procedure is normally performed using the radial artery in the wrist or the common carotid artery in the neck, any superficial artery that can be palpated may be used.



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Pulse

- Note whether the pulse is regular or irregular:
  - **Regular** - evenly spaced beats, may vary slightly with respiration
  - **Regularly Irregular** - regular pattern overall with "skipped" beats
  - **Irregularly Irregular** - chaotic, no real pattern, very difficult to measure rate accurately
- Count the pulse for 15 seconds and multiply by 4.
- Count for a full minute if the pulse is irregular.
- Record the rate and rhythm.

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Staff must report any arrythmias, irregularities in the pulse rate and pace to the doctor.

Pulse

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Pulse/Blood Pressure in Children

In children, pulse and blood pressure vary with the age. The following table should serve as a rough guide:

Average Pulse and Blood Pressure in Normal Children Age

	Birth	6mo	1yr	2yr	6yr	8yr	10yr
Pulse	140	130	115	110	103	100	95
Systolic	70	90	90	92	95	100	105

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Respiration rate, sometimes referred to as breathing rate, is the number of breaths taken per minute. This measurement is always taken when the individual is at rest.

A single respiration count is equal to the chest rising (inhalation) and falling (exhalation) once. The normal range for an adult is 12 to 28 respirations per minute.

Respiration Rate

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Respiration

https://youtu.be/wWAqkbD28uI

- Best done immediately after taking the patient's pulse. Do **not** announce that you are measuring respirations.
- Without letting go of the patient's wrist begin to observe the patient's breathing. Is it normal or labored?
- Count breaths for 15 seconds and multiply this number by 4 to yield the breaths per minute.
- In adults, normal resting respiratory rate is between 12-28 breaths/minute. Rapid respiration is called tachypnea.

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Temperature is considered normal at 98.6 degrees F (37 degrees C), although anything between 97.6 degrees F (36.4 degrees C) to 99.6 degrees F (37.5 degrees C) is acceptable.

A temperature over 100.4 degrees F (38 degrees C) indicates a fever caused by illness or injury. Hypothermia (low temperature) occurs when the body temperature dips below 95 degrees F (35 degrees C).

Body Temperature

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Temperature

Temperature can be measured in several different ways:

- **Oral** with a glass, paper, or electronic thermometer (normal 98.6F/37C)
- **Axillary** with a glass or electronic thermometer (normal 97.6F/36.3C)
- **Rectal** or "core" with a glass or electronic thermometer (normal 99.6F/37.7C)
- **Aural** (the ear) with an electronic thermometer (normal 99.6F/37.7C)

Of these, axillary is the least and rectal is the most accurate.

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Vital Signs Recap
Average Healthy Adults (at rest)

- Blood pressure: 90/60 mm Hg to 120/80 mm Hg
- Respiration: 12 to 18 breaths per minute
- Pulse: 60 to 100 beats per minute
- Temperature: 97.8°F to 99.1°F (36.5°C to 37.3°C)/average 98.6°F (37°C)

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Observation

- Observe the patient as they move thru the office, get in and out of the chair, actions while you are performing their history.
- Document what you see:
  - Walks with a limp
  - Difficulty getting out of chair
  - Appears to be in acute pain
  - Medical emergency

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Examination

- Observation
  - Gait Analysis
  - Postural
  - Function
- Palpation
- Range of Motion
- Orthopedic Tests
- Neurologic Evaluation
- Vascular Evaluation
- Visceral Evaluation
- X-ray/Lab Evaluation
- External Imaging or Specialty Referral

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Questions/Comments

Thank you!

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Scott Munsterman, DC, FICC, CPCO
Brief Bio

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Not everything is a nail…

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Be aware of patient's at-risk.

Recognize indications and contraindications for common modalities.

Know Red and Yellow Flags, Contraindications, etc.

At-Risk Patient Population

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Red Flags, Yellow Flags, CoMorbidities, and Risk Factors

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A serious condition that must be recognized through the history and exam process that typically requires referral to another health care provider

Clinical Red Flags

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No health care provider can automatically assume that red flags have already been picked up by other providers.

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Red Flags

Immediate Referral

1. Fracture/dislocation
   - Significant Trauma
   - Osteoporosis
   - Pathologic Fracture
2. Cancer/tumor
   - Night-time Pain
   - Severe Progressive
   - Unexplained Weight Loss
   - Prior History
3. Infection
   - Elevated Temperature
   - Night Sweats
   - Intravenous Drug Abuse
   - Immunosuppression
4. Vertebrobasilar involvement
5. Instability (including degenerative, surgical or rheumatoid etiologies)
6. Progressive scoliosis
7. Severe osteoporosis
8. Severe hypertension
9. Vertebrobasilar involvement
10. Visceral pathology
11. Inflammatory Arthritides
12. Cauda Equina Syndrome (loss of bladder/bowel function)

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75

In addition, stable conditions may become unstable, nonthreatening conditions may become threatening, and new conditions may arise or be present coincidentally.

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General Red Flags

Signs or symptoms that signal dangerous conditions with multiple possible explanations or that can manifest in many different anatomical areas.

Example: headache with a neurological deficit (i.e., due to tumor, bleeding, etc.)

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Common General Red Flags

1. Progressively decreasing mental function at any age (i.e., dementia, etc.) – up to 10% US population over 65 YOA, 85% of those 85 YOA and older.
2. Chronic or repeated dizziness occurring other than when standing up (i.e., cerebral neurohypofunction from decreased blood flow, oxygen, glucose, or toxins, etc. to the brain) – 10-40% of US population over 60 YOA.

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Specific Red Flags

Signal specific illnesses or are present in specific anatomical regions.

Example: injury to a body part (i.e., fracture)

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Common Specific Red Flags

1. Increasing confusion following head trauma (especially elderly person days, weeks, or months after minor head injury).
2. Sudden leg weakness and possible unconsciousness in elderly person when turning head (i.e., “Drop Attack” from vertebral artery insufficiency).

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Common Specific Red Flags

The timing of pain as a factor in red flags…

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Pain that worsens progressively over weeks to months is a general red flag for ongoing tissue damage.

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Pain that steadily increases in severity over weeks-to-months indicates a threat of irreversible tissue damage

Due to cancer, nerve damage, post-traumatic or post-surgical pain syndromes, inadequate blood supply to tissues, etc.)

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Progressively worsening pain after surgery is never normal.

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Increasingly painful area that turns numb is a red flag for sensory nerve destruction from advancing nerve compression syndromes.

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Worsening of any stable chronic recurring pain is also a red flag for new tissue necrosis or injury.

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A persistently inflamed joint is a general red flag – causing permanent joint and soft tissue damage if left untreated.

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An unexplained fracture caused by minimal or unidentified trauma is a red flag for some type of pathological deterioration of bone (i.e., osteoporosis, cancer, etc.)

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89

Severe immediate pain, numbness, weakness and/or loss of function after trauma is a general red flag for fracture or disruption of a vital structure.

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Fractures

It is a fallacy that a patient can't move an extremity if a fracture is present

Fractures are always painful to careful palpation: Palpation of the disrupted periosteum is always painful and is a reliable sign of fracture

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Severe pain and swelling in a joint immediately after trauma is a general red flag for ruptured arterial arteriolar vessels.

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Intense pain and skin changes persisting many weeks after trauma is a general red flag for complex regional pain syndrome (CRPS, causalgia, reflex sympathetic dystrophy)

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Abdominal pain and rigidity of abdominal muscles is a sign of irritation of the inner lining of the abdominal peritoneum from blood and/or pus.

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Low back pain with progressive leg numbness, tingling, and weakness.

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Back pain with insidious onset and progressive, unintentional weight loss.

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Back pain, Progressive bilateral leg weakness and erectile dysfunction in a man >40 years of age.

Cauda Equina Syndrome

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97

97

Cauda Equina Syndrome

McNamee J, Flynn P, O'Leary S, Love M, Kelly B. Imaging in cauda equina syndrome--a pictorial review. *Ulster Med J.* 2013;82(2):100-108. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3756868/

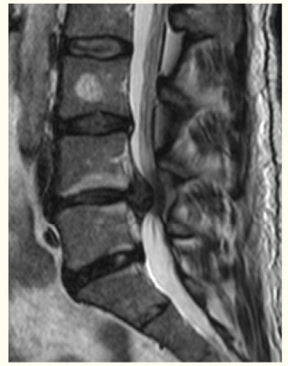

Fig 3a

Sagittal T2WI demonstrates a central disc herniation at L4-L5 with significant compression of the adjacent cauda equina nerve roots. Modic I end plate changes are also present at this level.

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Cauda Equina Syndrome is a serious condition caused by compression of the nerves in the lower portion of the spinal canal.

Cauda Equina Syndrome

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Cauda Equina Syndrome

Symptoms of cauda equina syndrome include the following:

- Low back pain
- Unilateral (single leg) or bilateral (both legs) sciatica (pain originating in the buttocks and traveling down the back of the thigh and legs)
- Saddle and perineal hypoesthesia or anesthesia (numbness in the groin or area of contact if sitting on a saddle)
- Bowel and bladder disturbances
- Lower extremity motor weakness and loss of sensations
- Reduced or absent lower extremity reflexes

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Severe, localized midline back pain with spinous process tenderness to percussion.

Compression fracture

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Sharp chest pain and shortness of breath with unilateral or bilateral ankle swelling.

Pulmonary embolus

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Persistent elbow pain and stiffness after a fall on an outstretched hand.

Fracture of radial head of humerus

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Elbow swelling and pain with diminished radial pulse and/or hand numbness after a fall.

Supracondylar fracture of humerus

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Headache, eye pain, blurry or haloed vision, nausea, vomiting.

Acute closed-angle glaucoma

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Sudden, cataclysmic headache in a middle-aged hypertensive patient.

Nontraumatic subarachnoid hemorrhage

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Atraumatic, progressive, intermittent hip pain on movement and decreased hip range of motion.

Avascular necrosis of the hip

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Hip, knee, groin pain with limp in obese adolescent with or without trauma with decreased hip range of motion on exam.

Slipped capital femoral epiphysis

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Late teen to early adult with focal, persistent shin pain after increasing running distance.

Stress fracture of the tibia

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Neck pain and progressive sensory changes and weakness in both arms and legs.

Spinal cord injury – Chiari malformation

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Shoulder pain and progressive inability to abduct the arm due to shoulder stiffness.

Adhesive capsulitis of the shoulder

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Pain on urination (dysuria) with high fever, chills, frequent urination, pain in the back and malaise.

Kidney infection

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Chronic tenderness in anatomic snuff box; pain of wrist after fall on outstretched hand.

Occult fracture of the scaphoid

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Resting heart rate >100/minute, hypervigilance, warm skin.

Hyperthyroidism

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Irregularly irregular pulse with rate >100/minute.

Atrial fibrillation

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15 minute episode of unilateral tingling/numbness that resolves completely.

Transient ischemic attack

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Slow onset of patchy numbness and weakness of more than one body part.

Multiple sclerosis

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Unilateral, painless lymph node swelling in the neck, arm or groin.

Lymphoma

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One-sided ankle/distal calf swelling or asymptomatic bilateral swelling (>3 cm difference).

Blood clot in a deep vein of the calf

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Bilateral, pitting ankle swelling with shortness of breath.

Congestive heart failure

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Swelling of one arm with shoulder and/or armpit (axillary) pain.

Subclavian vein deep venous thrombosis

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Sleeper Presentations

Represent far less drama than other red flags – common symptoms like constipation, low back pain which typically have non-serious causes and therefore the provider maybe "lulled" into a false sense of security.

Example: Low back pain: abdominal aortic aneurysm. Constipation: colon cancer.

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911 Situations:
How to Handle Emergencies

1. Call for help and dial/have someone dial 911 to activate emergency services system.
2. Provide CPR, basic life support, and first aid if needed until emergency service personal arrive.
3. Maintain communication with the 911 operator and ensure that the patient and the office are prepared for emergency services personnel.
4. You will be asked some basic questions about the patient's situation by the medical response team that comes to your office. These concerns will be forwarded to the ER staff.
5. You should meet the patient at the ED if your treatment caused harm.

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Falls Action Plan

1. Evaluate the person after the fall
   - Vitals, check for injury, call 911
2. Investigate fall circumstances
   - Factors, witnesses, etc.
3. Record circumstances and outcome
   - Date, time, detail, etc.
4. Alert person's primary care provider
   - falls assessment should be performed and a plan of care developed.
5. Implement immediate interventions within 24 hours
   - Awareness of high-risk people or situations and monitor compliance

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Co-Management, Consult, and Referrals

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Co-Management, Consult, and Referral Scenarios

Single Visit Consultation: A clinician decides a patient may need to seek another opinion. The referral clinician consults and evaluates the patient and then reports back to the patient and referring clinician the results of the visit.

Co-Management with Shared Care: This results when both the referring and referral clinicians decide there is benefit for the patient to combine their care plan and management, sharing the management of the patient by overseeing the scope of their treatment for the patient; but with communication between both clinicians regarding status of each care plan and response.

Co-Management with Principal Care: One of the clinicians involved becomes the captain of the team-based care model and is assigned the primary responsibility for the patient. The captain directs the care plan, involving other clinicians and providers in the process and delivery of care.

Transition of Care (for whole-person care): A clinician becomes responsible for the patient's whole care when a referral is made, transitioning the full responsibility of care to the referral clinician.

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1. Single Visit Consultation
2. Co-Management with Shared Care
3. Co-Management with Principal Care
4. Transition of Care for whole-person care
5. Communication of results to patient/family/caregiver

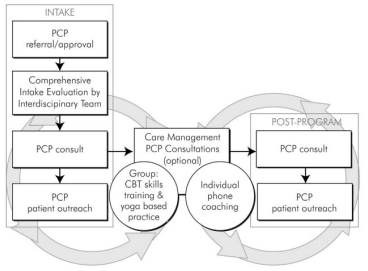

Fig. 2. PPACT intervention description.

https://www.contemporaryclinicaltrials.com/article/S1551-7144(17)30578-5/pdf

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1. Know who you need to work with on the care team.

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2. Determine what services you want the consult/referral provider to perform.

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3. Organize your clinical data logically in a consult/referral letter.

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4. Document your referral in the patient's chart

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5. Track the referral to close the loop.

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Tracking the Consult or Referral and Closing the Loop

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Patients without Red Flag Indicators

- Patients will be evaluated with a focused history and examination
- Patients will be evaluated with a thorough spinal examination
- Patients will complete the appropriate outcome measure and the patient will be monitored during the treatment plan with the outcome measure.

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A condition that must be recognized thru the history and exam process which requires the DC to be cautious when providing physical medicine to the patient and may require co-management with another health care provider

Cautious Considerations

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1. Osteoporosis
2. Congenitally blocked vertebrae
3. Rheumatoid arthritis
4. Seronegative arthropathies
5. Spinal stenosis
6. Spinal instability (i.e. listhesis)
7. A diagnosis of disc herniation or sequestration
8. Previous surgery
9. Use of corticosteroids or Cushing's disease
10. Use of anticoagulant medication
11. Positives on vertebrobasilar testing (if used) other than neurological responses

    (e.g. alternate position for adjustment if position induces a dizziness response)
12. Previous adverse reaction to a specific therapy or therapeutic trial

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"Yellow flags" are risk factors associated with chronic pain or disability.

Psychological Yellow Flags

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Yellow Flag Behaviors

Two or more could suggest substance use disorder

- Deterioration in functioning at work or socially
- Illegal activities—selling medications, forging prescriptions, or buying medications from nonmedical sources
- Using medications in ways other than prescribed (e.g., injecting or snorting medication)
- Multiple reports of lost or stolen prescriptions
- Resistance to change in medications despite adverse effects
- Refusal to comply with random drug screens, call backs, or pill counts
- Concurrent abuse of alcohol or drugs Use of multiple physicians and pharmacies

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Behavioral Comorbidities

- **Depression**
- History of Trauma/Abuse
- Personality Disorders
- Substance Abuse, Dependence, Addiction
- Opioid Use Disorder
- Anxiety Disorder
- Post Traumatic Stress Disorder
- Coping Skills/Catastrophizing
- Fear Avoidance

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Risk Factors with Strong Predictive Ability for developing chronic pain and disability

- Fear avoidance beliefs
- Catastrophizing
- Somatization
- Depressed mood
- Distress and anxiety
- Early disability or decreased function
- High initial pain levels
- Increased age
- Poor general health status
- Non-organic signs
- Secondary gain (occupational, social, family, financial)

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Vulnerable Populations

Diagnosis or treatment is significantly limited by social determinants of health

(i.e., economic and social conditions that influence access to care, etc.)

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Differential Diagnosis

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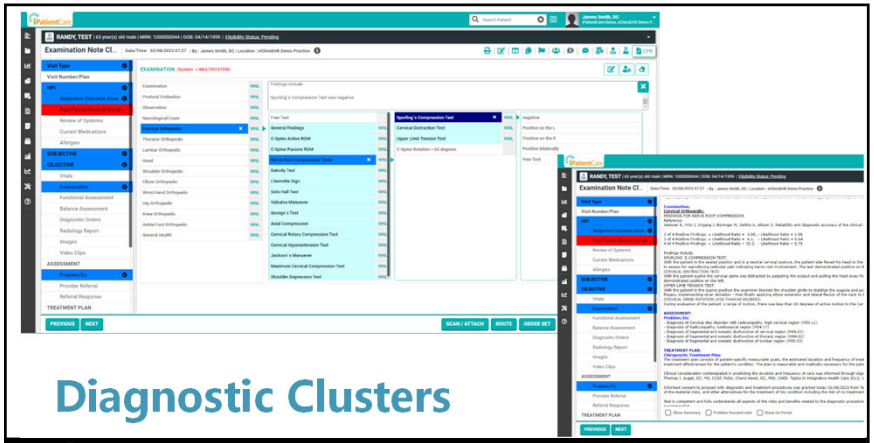

Diagnostic Clusters

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Radiographic Indications

When is it clinically indicated to perform radiographs or other imaging?

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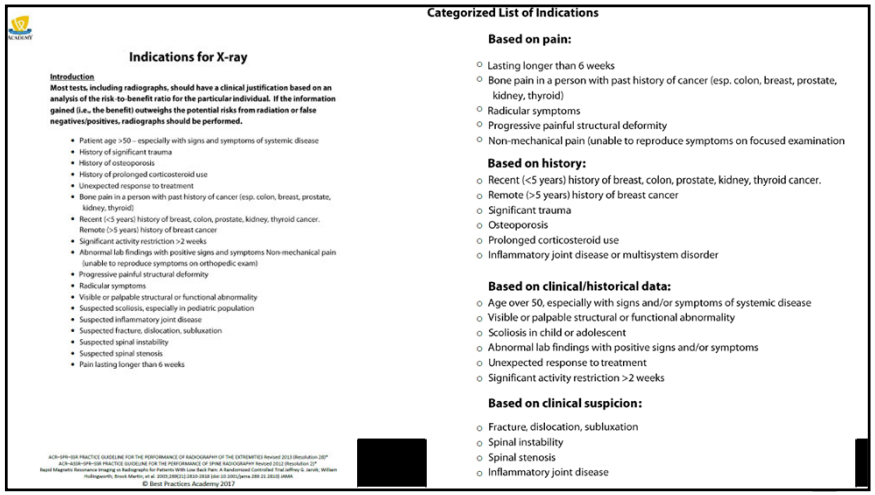

Categorized List of Indications

Indications for X-ray

Introduction

Most tests, including radiographs, should have a clinical justification based on an analysis of the risk-to-benefit ratio for the particular individual. If the information gained (i.e., the benefit) outweighs the potential risks from radiation or false negatives/positives, radiographs should be performed.

- Patient age >50 – especially with signs and symptoms of systemic disease
- History of significant trauma
- History of osteoporosis
- History of prolonged corticosteroid use
- Unexpected response to treatment
- Bone pain in a person with past history of cancer (esp. colon, breast, prostate, kidney, thyroid)
- Recent (<5 years) history of breast, colon, prostate, kidney, thyroid cancer. Remote (>5 years) history of breast cancer
- Significant activity restriction >2 weeks
- Abnormal lab findings with positive signs and symptoms Non-mechanical pain (unable to reproduce symptoms on orthopedic exam)
- Progressive painful structural deformity
- Radicular symptoms
- Visible or palpable structural or functional abnormality
- Suspected scoliosis, especially in pediatric population
- Suspected inflammatory joint disease
- Suspected Fracture, dislocation, subluxation
- Suspected spinal instability
- Suspected spinal stenosis
- Pain lasting longer than 6 weeks

Based on pain:

- Lasting longer than 6 weeks
- Bone pain in a person with past history of cancer (esp. colon, breast, prostate, kidney, thyroid)
- Radicular symptoms
- Progressive painful structural deformity
- Non-mechanical pain (unable to reproduce symptoms on focused examination

Based on history:

- Recent (<5 years) history of breast, colon, prostate, kidney, thyroid cancer.
- Remote (>5 years) history of breast cancer
- Significant trauma
- Osteoporosis
- Prolonged corticosteroid use
- Inflammatory joint disease or multisystem disorder

Based on clinical/historical data:

- Age over 50, especially with signs and/or symptoms of systemic disease
- Visible or palpable structural or functional abnormality
- Scoliosis in child or adolescent
- Abnormal lab findings with positive signs and/or symptoms
- Unexpected response to treatment
- Significant activity restriction >2 weeks

Based on clinical suspicion:

- Fracture, dislocation, subluxation
- Spinal instability
- Spinal stenosis
- Inflammatory joint disease

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X-ray
Lab
Special Imaging (MRI, CT, DEXA, US)
Electrodiagnostic studies

Advanced Studies

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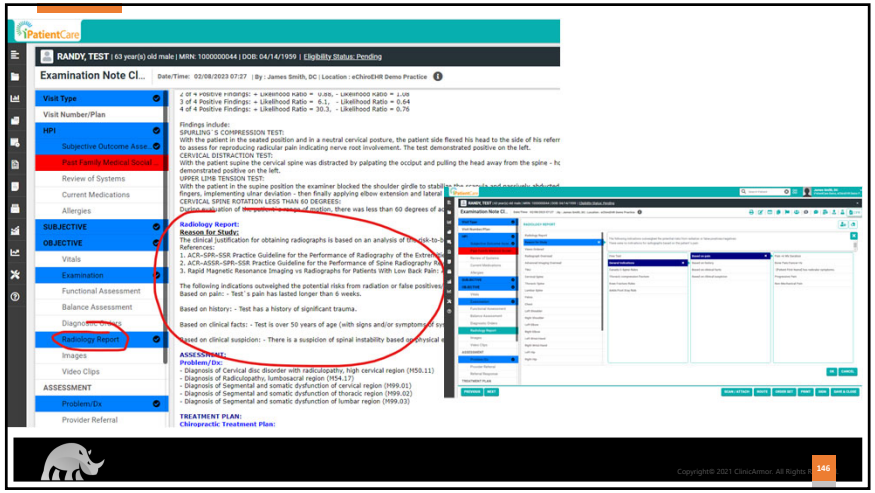
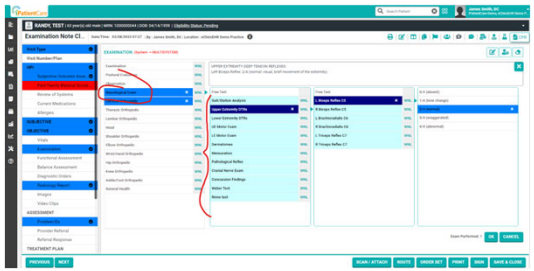


146

Neurological Evaluation

- Upper/Lower Motor exam
- Deep tendon Reflexes
- Sensory exam
- Cranial Nerve Exam



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Informed Consent

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Consent by a person to undergo a medical procedure, participate in a clinical trial, or be counseled by a professional such as a social worker or lawyer, after receiving all material information regarding risks, benefits, and alternatives.

informed consent. (n.d.) *The American Heritage® Medical Dictionary*. (2007). Retrieved May 26 2020 from https://medical-dictionary.thefreedictionary.com/informed+consent

Patient Safety
Informed Consent

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150

18-19

https://www.menti.com/alik7oiwxz5f

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Informed Consent Process

Informing patients properly depends upon the sequence and information provided to disclose material risk.

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Discussion between the Clinician and the Patient

Obtain the patient's informed consent to the procedures **after** they have been provided material information **and** discussion with the doctor about all of the alternatives or risks of care.

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Informed Consent **must be obtained annually** and with new patients as part of the intake procedure and/or upon **re-admit, new diagnosis, new evidence, or new treatment**.

Informed Consent Process

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Informed Consent Process

PROCEDURE:

1. Upon patient's check-in, staff provides the unsigned Informed Consent form to the patient following taking the patient's history.
2. Informed Consent is reviewed and discussed with the patient **BY THE CLINICIAN**, at the time of visit, immediately after health history and exam and **prior to treatment and diagnostic procedures**. Any questions the patient may have are answered, always by the clinician.
3. Patient signs and dates form; clinician signs and dates form;
4. Completed form gets turned in to the front desk and gets scanned into patient record – or is signed within the EHR system records directly.

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When do we use Informed Consent?

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Every new patient and those patients who are re-admitted for care due to a new injury or condition, etc.

New Patient/Re-Admit

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New Diagnosis

A new diagnosis for the patient represents a material change for the patient.

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New evidence regarding treatment and/or procedures may represent a material change for the patient for consideration of alternative treatment or procedures. New risks for specific treatments/procedures should be updated in the informed consent form as well.

New Evidence

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A change in the use of a procedure in the care of the patient regardless of a change in the diagnosis.

New Treatment Procedure

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Six Key Elements of Informed Consent

For the patient's consent to be valid, the following elements need to be reviewed with the patient:

1. The patient's diagnosis/condition and the proposed treatment, modality or procedures for correction.
2. The relevant risks and benefits of the proposed treatment, modality or procedures
3. Alternative treatment or procedures that are available to the patient and the relative risk, benefits, and uncertainties related to each alternative;
4. The risk and benefits of not receiving or undergoing any treatment procedure
5. The assessment of the patients understanding of the information provided (decision making capacity)
6. The acceptance by the patient to undergo the recommended treatment, modality or procedure.

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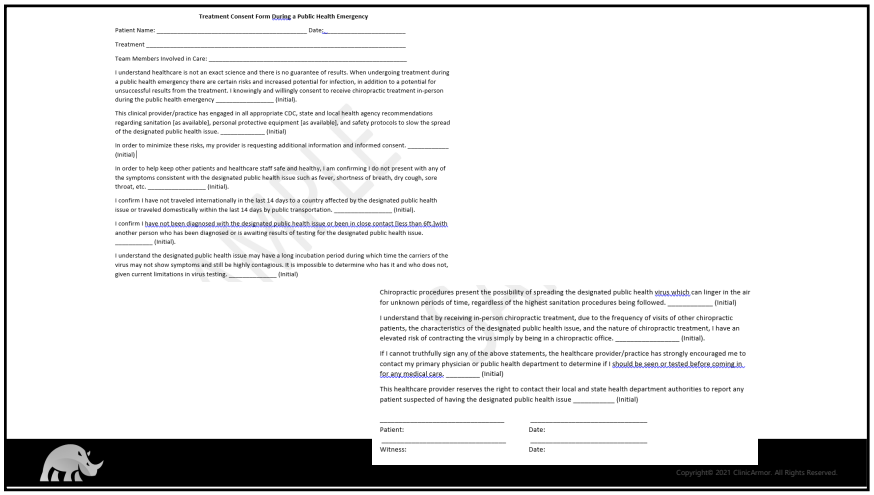

Treatment Consent Form During a Public Health Emergency

Patient Name: _____ Date:_____

Treatment _____

Team Members Involved in Care: _____

I understand healthcare is not an exact science and there is no guarantee of results. When undergoing treatment during a public health emergency there are certain risks and increased potential for infection, in addition to a potential for unsuccessful results from the treatment. I knowingly and willingly consent to receive chiropractic treatment in-person during the public health emergency _____ (Initial).

This clinical provider/practice has engaged in all appropriate CDC, state and local health agency recommendations regarding sanitation (as available), personal protective equipment (as available), and safety protocols to slow the spread of the designated public health issue. _____ (Initial)

In order to minimize these risks, my provider is requesting additional information and informed consent. _____ (Initial)|

In order to help keep other patients and healthcare staff safe and healthy, I am confirming I do not present with any of the symptoms consistent with the designated public health issue such as fever, shortness of breath, dry cough, sore throat, etc. _____ (Initial).

I confirm I have not traveled internationally in the last 14 days to a country affected by the designated public health issue or traveled domestically within the last 14 days by public transportation. _____ (Initial).

I confirm I have not been diagnosed with the designated public health issue or been in close contact (less than 6ft)with another person who has been diagnosed or is awaiting results of testing for the designated public health issue. _____ (Initial).

I understand the designated public health issue may have a long incubation period during which time the carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given current limitations in virus testing. _____ (Initial)

Chiropractic procedures present the possibility of spreading the designated public health virus which can linger in the air for unknown periods of time, regardless of the highest sanitation procedures being followed. _____ (Initial)

I understand that by receiving in-person chiropractic treatment, due to the frequency of visits of other chiropractic patients, the characteristics of the designated public health issue, and the nature of chiropractic treatment, I have an elevated risk of contracting the virus simply by being in a chiropractic office. _____ (Initial).

If I cannot truthfully sign any of the above statements, the healthcare provider/practice has strongly encouraged me to contact my primary physician or public health department to determine if I should be seen or tested before coming in for any medical care. _____ (Initial)

This healthcare provider reserves the right to contact their local and state health department authorities to report any patient suspected of having the designated public health issue _____ (Initial)

Patient: _____ Date: _____

Witness: _____ Date: _____

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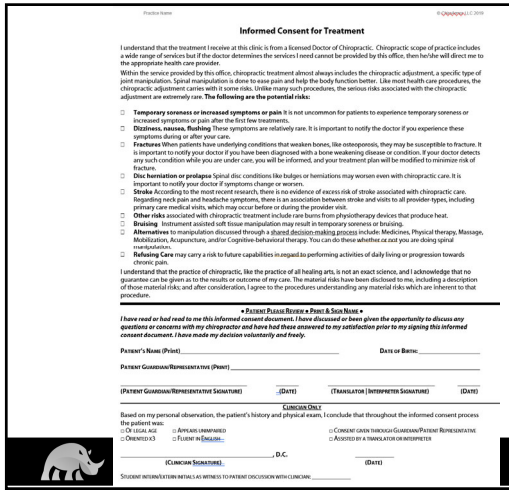

Practice Name © Copyright LLC 2008

Informed Consent for Treatment

I understand that the treatment I receive at this clinic is from a licensed Doctor of Chiropractic. Chiropractic scope of practice includes a wide range of services but if the doctor determines the services I need cannot be provided by this office, then he/she will direct me to the appropriate health care provider.

Within the service provided by this office, chiropractic treatment almost always includes the chiropractic adjustment, a specific type of joint manipulation. Spinal manipulation is done to ease pain and help the body function better. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. **The following are the potential risks:**

- ☐ **Temporary soreness or increased symptoms or pain** It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.
- ☐ **Dizziness, nausea, flushing** These symptoms are relatively rare. It is important to notify the doctor if you experience these symptoms during or after your care.
- ☐ **Fractures** When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your doctor if you have been diagnosed with a bone weakening disease or condition. If your doctor detects any such condition while you are under care, you will be informed, and your treatment plan will be modified to minimize risk of fracture.
- ☐ **Disc herniation or prolapse** Spinal disc conditions like bulges or hernias may worsen even with chiropractic care. It is important to notify your doctor if symptoms change or worsen.
- ☐ **Stroke** According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. Regarding neck pain and headache symptoms, there is an association between stroke and visits to all provider-types, including primary care medical visits, which may occur before or during the provider visit.
- ☐ **Other risks** associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.
- ☐ **Bruising** Instrument assisted soft tissue manipulation may result in temporary soreness or bruising.
- ☐ **Alternatives** to manipulation discussed through a shared decision-making process include: Medicines, Physical therapy, Massage, Mobilization, Acupuncture, and/or Cognitive-behavioral therapy. You can do these whether or not you are doing spinal manipulation.
- ☐ **Refusing Care** may carry a risk to future capabilities in regard to performing activities of daily living or progression towards chronic pain.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care. The material risks have been disclosed to me, including a description of those material risks; and after consideration, I agree to the procedures understanding any material risks which are inherent to that procedure.

• Patient Please Review • Print & Sign Name •

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

Patient's Name (Print)_____ Date of Birth: _____

Patient Guardian/Representative (Print) _____

_____ _____ _____ _____

(Patient Guardian/Representative Signature) (Date) (Translator | Interpreter Signature) (Date)

Clinician Only

Based on my personal observation, the patient's history and physical exam, I conclude that throughout the informed consent process the patient was:

☐ Of legal age ☐ Appears unimpaired ☐ Consent given through Guardian/Patient Representative

☐ Oriented x3 ☐ Fluent in English ☐ Assisted by a translator or interpreter

_____, D.C. _____

(Clinician Signature) (Date)

Student intern/extern initials as witness to patient discussion with clinician: _____

Informed Consent Form

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Six Exceptions of Informed Consent

(1) Detailed technical information that in all probability a patient would not understand.

(2) Risks apparent or known to the patient.

(3) **Extremely remote possibilities that might falsely or detrimentally alarm the patient.**

(4) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.

(5) Information in cases where the patient is incapable of consenting.

(6) Information about alternate modes of treatment for any condition the chiropractor has not included in his or her diagnosis at the time the chiropractor informs the patient.

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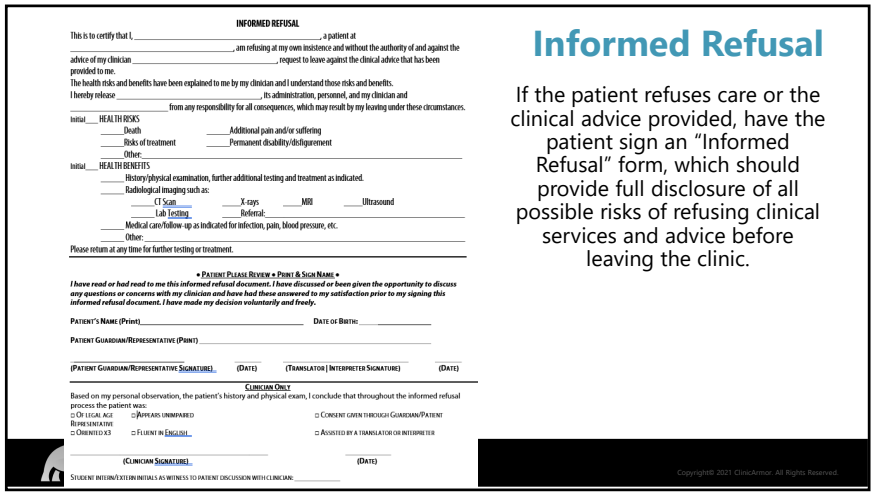

INFORMED REFUSAL

This is to certify that I, _____, a patient at _____, am refusing at my own insistence and without the authority of and against the advice of my clinician _____, request to leave against the clinical advice that has been provided to me.
The health risks and benefits have been explained to me by my clinician and I understand those risks and benefits.
I hereby release _____, its administration, personnel, and my clinician and _____ from any responsibility for all consequences, which may result by my leaving under these circumstances.

Initial___ HEALTH RISKS
_____Death _____Additional pain and/or suffering
_____Risks of treatment _____Permanent disability/disfigurement
_____Other:_____
Initial___ HEALTH BENEFITS
_____History/physical examination, further additional testing and treatment as indicated.
_____Radiological imaging such as:
_____CT Scan ____X-rays ____MRI ____Ultrasound
_____Lab Testing ____Referral:_____
_____Medical care/follow-up as indicated for infection, pain, blood pressure, etc.
_____Other:_____
Please return at any time for further testing or treatment.

• PATIENT PLEASE REVIEW • PRINT & SIGN NAME •

I have read or had read to me this informed refusal document. I have discussed or been given the opportunity to discuss any questions or concerns with my clinician and have had these answered to my satisfaction prior to my signing this informed refusal document. I have made my decision voluntarily and freely.

PATIENT'S NAME (PRINT)_____ DATE OF BIRTH: _____

PATIENT GUARDIAN/REPRESENTATIVE (PRINT) _____

_____ _____ _____ _____
(PATIENT GUARDIAN/REPRESENTATIVE SIGNATURE) (DATE) (TRANSLATOR | INTERPRETER SIGNATURE) (DATE)

CLINICIAN ONLY

Based on my personal observation, the patient's history and physical exam, I conclude that throughout the informed refusal process the patient was:
□ OF LEGAL AGE □ APPEARS UNIMPAIRED □ CONSENT GIVEN THROUGH GUARDIAN/PATIENT REPRESENTATIVE
□ ORIENTED X3 □ FLUENT IN ENGLISH □ ASSISTED BY A TRANSLATOR OR INTERPRETER

_____ _____
(CLINICIAN SIGNATURE) (DATE)

STUDENT INTERN/EXTERN INITIALS AS WITNESS TO PATIENT DISCUSSION WITH CLINICIAN: _____

Informed Refusal

If the patient refuses care or the clinical advice provided, have the patient sign an "Informed Refusal" form, which should provide full disclosure of all possible risks of refusing clinical services and advice before leaving the clinic.

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Treatment

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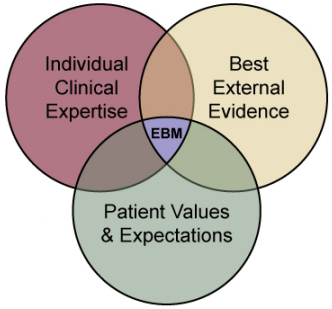
Evidence-Informed Practice



The Evidence-based Medicine Triad
Source: Florida State University, College of Medicine.

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Standard of Care

How does your state licensing board view YOUR responsibilities as a clinician, within the interest of public safety?

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Clinical Competencies

Efficacious Treatment Approaches

Competency of Doctor and Staff in delivery of services

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Are you and your staff attending regular clinical education training?

Do you provide hands-on training for staff?

Are you using FDA approved devices?

Does your treatment follow guidelines?

Are you monitoring and documenting the progress of your patients?

Questions to Ask

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Misinformed Treatment Plans

Communicating to patients regarding the treatment plan and expectations of care process.

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Care Management Considerations

Transitional Care (Hand-off)

Environment/Falls

Medication Errors/Reconciliation

Team/Communication

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Dry Needling/Acupuncture Adverse Effects

The act of puncturing the skin comes with a number of predictable adverse events (bruising or bleeding, pain during or following treatment) which commonly occur and are mild in nature.

This may be considered normal side effects of treatment. However, from the patient's perspective they may be considered adverse particularly if the patient has not been educated about the risks associated with their dry needling/acupuncture technique.

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Manipulation/Manual Therapy
Potential Risks

- ✓Temporary soreness or increased symptoms or pain It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.
- ✓Dizziness, nausea, flushing These symptoms are relatively rare. It is important to notify the doctor if you experience these symptoms during or after your care.
- ✓Fractures When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your doctor if you have been diagnosed with a bone weakening disease or condition. If your doctor detects any such condition while you are under care, you will be informed, and your treatment plan will be modified to minimize risk of fracture.
- ✓Disc herniation or prolapse Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your doctor if symptoms change or worsen.
- ✓Stroke According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. Regarding neck pain and headache symptoms, there is an association between stroke and visits to all provider-types, including primary care medical visits, which may occur before or during the provider visit.
- ✓Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.
- ✓Bruising Instrument assisted soft tissue manipulation may result in temporary soreness or bruising.

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Chiropractic Clinical Assistant Competency

- Formal training completion with testing
- Understand supervision rules for your state
- Patient response
- Doctor communication - orders

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Recognizing and Preventing Safety Hazards

1. Therapy Modalities
2. Hydraulic/Spring-loaded adjusting tables
3. Sharps (i.e. needles) and Sharps Containers
4. Theraband/Exercise Stations

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Therapeutic Modalities and Table Equipment

- Are all therapeutic modalities and equipment (both, company and employee-owned) used by staff, providers and workforce members at their workplace in good condition?
- Are all of the operating manuals and instructions available to staff, providers and workforce members for all therapeutic modalities and equipment?
- Are staff, providers and workforce members made aware of the hazards caused by faulty or improperly used modalities and equipment?
- Are all cord-connected, electrically operated modalities and equipment effectively grounded or of the approved double insulated type?
- Are children monitored at all times and parent/guardian warned of crush risk or safety issue around modalties?

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Therapeutic Modalities and Table Equipment

- Are all therapeutic modalities and equipment turned off after use and remain off prior to patient use?
- Do patients know what to expect prior to the application of the modality?
- Do patients know what to expect as potential temporary symptoms or reactions to the application of the therapy?

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Theraband Exercise Station

Eye Protection

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OSHA Safety Considerations

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Key Concepts to Understand

Hazard refers to the inherent properties of a chemical, work practice, equipment, etc. that make it capable of causing harm to a person or the environment.

Exposure describes both the amount of, and the frequency with which, a hazard comes into contact with a person, group of people or the environment.

Risk is the possibility of a harm arising from a particular exposure to a hazard, under specific conditions.

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Emergency Disaster Policy

The policy is to protect the patients, staff and clinicians in the event of an action or an occurrence that poses a threat to life or property. Procedures will be adopted to address as much as possible events that would threaten the lives and health of patients, staff and clinicians.

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Emergency Disaster Policy & Procedure

- Immediate Actions Following an Emergency
- Bomb Threat
- Loss of Critical Utilities
- Emergency Assistance
- Business Data Backup
- Cardiac/Respiratory Arrest Protocol
- Tornado/Severe Weather Plan
- Terrorist Chemical/Biological Threat Exposure
- Security
- Emergency Action Plan

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Emergency Action Plan

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Emergency Action Plan

- Alerts
- Policy on Evacuation
- Routes
- Extinguishers
- Operations shutdown
- Duties assigned
- Assembly after an evacuation
- Accounting

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OSHA's New COVID-19 Standard Update

Managing Risk for Staff and Doctors

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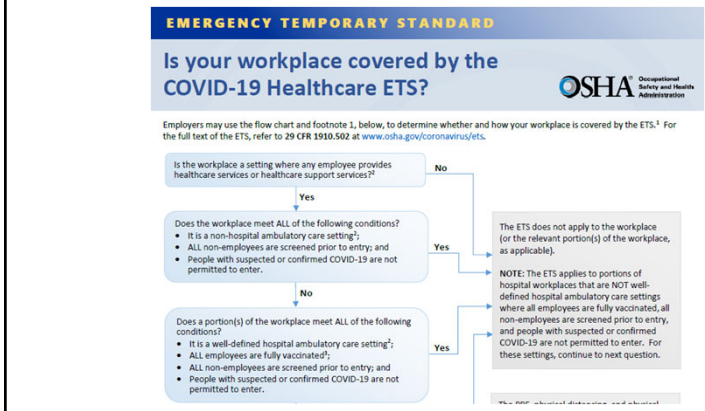

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References

OSHA

https://www.osha.gov/coronavirus/control-prevention

https://www.osha.gov/coronavirus/safework

CDC

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-after-vaccination.html#print

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Preventing Blood-borne Pathogens

Bloodborne Pathogen Standard Policy
Sharps/Needle sticks

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Preventing Air-borne Pathogens

Exposure Control Plan

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Mitigating the Exposure Risk

COVID-19 Screening (patients/workers)
Assess Community Spread
Implement Multiple Layers of Controls

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COVID-19 Screening

1. Are you COVID–19 positive or been told by a licensed healthcare provider that you are suspected to have COVID–19?
2. Are you experiencing recent loss of taste and/or smell with no other explanation?
3. Are you experiencing both fever (≥100.4 °F) and new unexplained cough associated with shortness of breath?

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Non-worker Screening

Patients and Visitors

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Worker Screening

Self-Screening Program

On-site Screening Program

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Medical Records

Note that 29 CFR 1910.1020 may apply to temperature records if you are providing on-site worker screening…

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Should workers in settings not covered by the Healthcare ETS wear cloth face coverings while at work?

OSHA's guidance is consistent with the Centers for Disease Control and Prevention (CDC. In addition to unvaccinated and otherwise at-risk workers, CDC recommends that even fully vaccinated people wear masks in public indoor settings in areas of substantial or high transmission and notes that fully vaccinated people may appropriately choose to wear a mask in public indoor settings regardless of level of transmission, particularly for people who are at-risk or have someone in their household who is at-risk or not fully vaccinated. Unless otherwise provided by federal, state, or local requirements, workers who are outdoors may opt not to wear face coverings unless they are at risk, for example, if they are immunocompromised. Regardless, all workers should be supported in continuing to wear a face covering if they choose, especially in order to safely work closely with other people.

Note that cloth face coverings are not considered personal protective equipment (PPE) and cannot be used in place of respirators when respirators are otherwise required.

Learn more about cloth face coverings on the CDC website.

Employers may need to provide reasonable accommodation for any workers who are unable to wear or have difficulty wearing certain types of face coverings due to a disability or who need a religious accommodation. In workplaces with employees who are deaf or have hearing deficits, employers should consider acquiring masks with clear coverings over the mouth to facilitate lip-reading.

For information about masking requirements for public transportation conveyances and transportation hubs check with the CDC.

Do we still need to use facemasks?

https://www.osha.gov/coronavirus/faqs#cloth-face-coverings

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The agency now says that facilities in areas without high transmission can decide for themselves whether to require everyone — doctors, patients, and visitors — to wear masks.

Community transmission "is the metric currently recommended to guide select practices in healthcare settings to allow for earlier intervention, before there is strain on the healthcare system and to better protect the individuals seeking care in these settings," the CDC said.

https://www.medscape.com/viewarticle/981629?src=WNL_dne1_220930_MSCPEDIT&uac=395626EV&impID=4698875&faf=1

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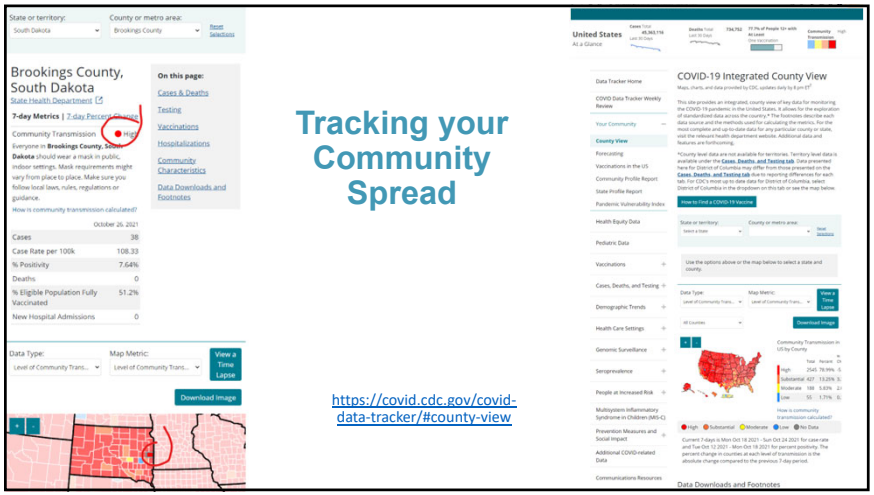

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"substantial or high transmission"

The key is "substantial or high transmission" which needs to be evaluated here:
https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=Risk

You can see where your county is at in transmission rates, and then make the face mask decision accordingly.

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Multiple Layers of Controls

Removing from the workplace all infected people
Mask wearing
Distancing
Increased ventilation
Proper cleaning/disinfecting
Proper hand hygiene
Training

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What types of safety equipment are available?

- Fire extinguisher
- CPR equipment (AED, CPR Masks/Supplies)
- Gloves
- Face Masks
- Disinfectant
- Alcohol-based hand rub
- Handwashing Station
- Blood Draw Equipment
- KNOWLEDGE

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Re-Cap

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Clinical Conscientiousness

Maintaining your clinical mindset

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Clinical Awareness

Ongoing process…

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The "Walk"

Welcome
Ask
Listen
Knowledge

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Screening Patients:

Monitor changes since the last visit
No change or worsening
Observation of patient's behaviors and characteristics

Has there been a "Significant Event"?

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Does the patient's clinical presentation require urgent need for evaluation and/or care?

The doctor must be informed of any new information about the patient that has been related to staff.

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Stay Connected to Established Patients who are under a treatment plan.

Following the treatment plan, evidence-informed care guidelines, and the patient's response to care...

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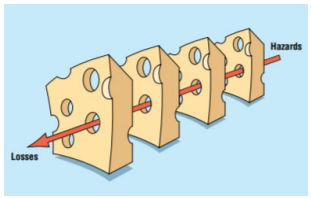
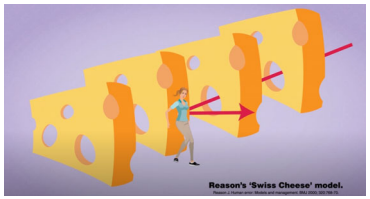
It just takes one thing to block the incident…



https://www.youtube.com/watch?v=7Y8HupZ2e0s&feature=youtu.be



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Thank you!

Scott Munsterman, DC, FICC, CPCO

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1

Risk Management in the Chiropractic Office

Defining risk management is easy - but applying it successfully to practice operations begins with fully understanding all your potential risks.

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2

https://www.menti.com/al6t26wu1zo2

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3

Federal, state, and local governmental agencies enforce regulations (HIPAA, OSHA, OIG, Medicare, etc.) upon the healthcare industry. In addition, the standard of care for health care providers - governed by their respective licensing board - upholds consumer protections through accountability mechanisms.

Covering these bases and more through a risk management or compliance program is your first step to protecting your patients, your practice, and your future."

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What Is Risk Management in Healthcare?

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Enterprise Risk Management
On July 15, 2016, the
Office of Management and Budget (OMB)
released guidance that requires federal agencies to implement enterprise risk management (ERM).

ERM extends beyond compliance and financial risk by using a comprehensive approach to view risks across five categories: compliance, financial, operational, reputational, and strategic.

https://www.cdc.gov/about/organization/riskmanagement.html

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Risk Philosophy

CDC embraces **intelligent risk management**—obtaining risk data, applying analytics, and producing actionable risk information to guide decision-making—as a means to fulfill its public health mission of protecting the nation's health security.

Organizations cannot survive, much less thrive, if they avoid risk altogether. Embracing a culture of risk awareness across CDC—with supporting risk mitigation through management systems and processes—provides the foundation for intelligent risk management.

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A solid framework encompassing a common risk language, integrated risk assessments and response system, and frequent risk monitoring and risk communication ensures that risk intelligence is considered and continuously available to decision-makers.

The world in which CDC operates is dynamic and requires action, and CDC's ERM framework should reflect this.

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Risk Appetite

Risk appetite is defined as the level and type of risk an organization is willing to accept in pursuit of its objectives. Risks have both positive and negative consequences.

- Risk appetite may shift due to a variety of factors (i.e., changes in regulations)
- Discretion is exercised within broad guidelines in applying risk appetite to decision-making.
- Caution is exercised when accepting risks that have the potential to negatively impact the public's trust and confidence.
- Continue to develop, implement and update policies and procedures that reflect its appetite for risk in pursuit of an organization's mission.

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Risk management in healthcare comprises the clinical and administrative systems, processes, and reports employed to detect, monitor, assess, mitigate, and prevent risks.

By employing risk management, healthcare organizations proactively and systematically safeguard patient safety as well as the organization's assets, market share, accreditation, reimbursement levels, brand value, and community standing.

NEJM catalyst innovations in care delivery. Publication type: e-Journal. ISSN: 2642-0007. Publication Year: 2018 – Present.
Publisher: Massachusetts Medical Society. Country: United States of America.
https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0197

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Risk Assessment

Patient safety
Mandatory federal regulations
Potential medical error
Existing and future policy
Legislation impacting the field of healthcare

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Risk Assessment and Analysis should identify:

What could possibly happen?

How likely is something to happen (measuring risk)?

How severe will the outcome be if something did happen?

How can the likelihood something will happen be mitigated on the forefront and to what degree?

What can be done to reduce the impact (and to what degree)?

What is the potential for exposure or what cannot be proactively avoided?

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Using analysis results, risk managers can compare the likelihood of different adverse events along with their impacts and rank potential risks in terms of severity.

Plans for mitigating risks and handling them appropriately can then be developed.

Risk management plans also undergo quality assessment so the interventions and actions proposed are addressed as real potential issues.

Once a strategy is in place, itis monitored and modified as needed.

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Policy Gap Analysis Tool

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Risk Management plans are specific to different healthcare facilities. While avoiding potential financial consequences is one concern, patient needs are generally the priority

https://elearning.scranton.edu/resources/article/purpose-of-risk-management-in-healthcare/

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Since risk management involves managing uncertainty and new risk is constantly emerging, it is challenging to recognize all the threats a healthcare entity faces.

However, through the use of data, institutional and industry knowledge, and by engaging everyone — patients, employees, administrators, and payers—healthcare risk managers can uncover threats and potentially compensatory events that otherwise would be hard to anticipate

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With the OIG laying down fines of $11,000.00 USD or more for every claim filed for services performed by sanctioned or excluded vendors or individuals.

Healthcare providers need to proactively mitigate their risk by conducting real-time monitoring or audits on their third-party business associates, vendors, contractors, and employees.

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How To Have Effective Risk Management

1. First, you need to identify the types of risks your organization is susceptible to.
2. After you identify the potential threats, you need to evaluate them.
3. The third step for risk management is to mitigate the risk. This is done by implementing your risk management process.
4. After mitigating the risk, you need to constantly work your risk management plan to see how effective it has been through monitoring and auditing processes.
5. Finally, you need to document and report on the effectiveness of your plan. This will help your employees and business leaders know that you are doing everything to keep your company safe.

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What is included in a compliance program?

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Compliance Work Plan: The Operating System

Seven Basic Components

1. Designating a compliance officer
2. Implementing Standards
3. Monitoring and auditing
4. Training and education
5. Responding to violations
6. Open communication
7. Enforcing disciplinary standards

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Establishing Priorities

- **Are there any pending legal, compliance or employee issues in the practice?**
- **Do you offer discounts?**
- **Do you extend professional courtesies?**
- **Do you rent or own space – professional relationships present?**
- **Do you have ownership in external health care facilities/diagnostic centers?**
- **What EHR system do you use? Back-up/Disaster Recovery Plan in place?**
- **Do you contract with payers? If so, how do you manage your fee schedules currently? When was the last time you reviewed your fees and practice expense ratio?**
- **Staff retention/longevity: Training needs identified?**
- **Do you want the practice to grow or maintain?**
- **What is your current Medicare Claims Volume? Previously report PQRS?**

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Regulatory Standards

Employment
HIPAA
OSHA
Medicare/Medicaid
Coding and Billing
Documentation

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Employment Policy Components

- Governance
- Administration
- Employment Applications
- Employment Relationship
- Non-Discrimination
- Non-Disclosure/Confidentiality
- New Employee Orientation
- Probationary Period for New Employees
- Office Hours
- Lunch Periods
- Break Periods
- Personnel Files
- Personnel Data Changes
- Inclement Weather/Emergency Closings
- Performance Review and Planning Sessions
- Outside Employment
- Corrective Action
- Employment Termination
- Safety
- Health Related Issues
- Employee Requiring Medical Attention
- Building Security
- Insurance on Personal Effects
- Supplies; Expenditures; Obligating the Company
- Expense Reimbursement
- Parking
- Visitors in the Workplace
- Immigration Law Compliance
- Attendance/Punctuality
- Absence Without Notice
- Harassment, including Sexual Harassment
- Telephone Use
- Public Image
- Substance Abuse
- Tobacco Products
- Internet Use
- Wage or Salary Increases
- Timekeeping
- Overtime
- Paydays
- Insurance
- Cobra Benefits
- Social Security/Medicare
- Simple IRA
- Vacation
- Record Keeping
- Holidays
- Jury Duty/Military Leave
- Educational Assistance
- Training and Professional Development
- Staff Meetings
- Bulletin Boards
- Suggestion Box
- Procedure for Handling Complaints

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HIPAA Privacy Rule

Defined a Record Set
Minimum Necessary Uses and Disclosures
Notice of Privacy Practices
Storing PHI
Transmitting PHI
Accounting of Disclosures

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HIPAA Administrative Safeguard Standards

- Log-in Monitoring
- Password Management
- Response and Reporting
- Contingency Plan
- Data Backup Plan
- Disaster Recovery Plan
- Emergency Mode Operation Plan
- Testing and Revision Procedures
- Applications and Data Criticality Analysis
- Evaluation
- Business Associate Contracts and Other Arrangements
- Risk Analysis
- Risk Management
- Sanction Policy
- Information System Activity Review
- Assigned Security Responsibility
- Authorized and Supervision
- Workforce Clearance Procedure
- Termination Procedures
- Healthcare Clearinghouse Functions
- Access Authorization
- Access Established and Modification
- Security Reminders
- Protection from Malicious Software

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HIPAA Physical Safeguard Standards

- Contingency Operations
- Facility Security Plan
- Access Control and Validation Procedures
- Maintenance Records
- Workstation Use
- Workstation Security
- Device and Media Controls
- Device and Media Controls – Disposal
- Device and Media Controls – Media Re-use
- Device and Media Controls – Accountability
- Device and Media Controls – Data Backup and Storage

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HIPAA Technical Safeguard Standards

- Access Control
- Unique User ID
- Emergency Access Procedure
- Automatic Log-off
- Encryption and Decryption
- Audit Controls
- Mechanism to Authenticate Electronic Patient Health Information
- Person or Entity Authentication
- Integrity Control
- Encryption

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Security Risk Analysis

Conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the covered entity.

Includes addressing the security (including encryption) of electronic personal health information created or maintained by CEHRT; implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.

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OSHA Requirements

General Safety Policy

Bloodborne Pathogen Policy and/or Exposure Management Plan

Hazard Communication Program

Ionizing Radiation

Emergency Action Plan

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Medicare Policy

- Opt out
- Lincoln Law
- Professional Courtesy
- OIG Exclusion List
- Par versus Non-Par
- The 97140 Scheme
- Billing Services
- Informed Consent
- Security Risk Analysis
- Documentation

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There are 45 activities monitored and 12 key procedures audited throughout the year.

Are you documenting your compliance?

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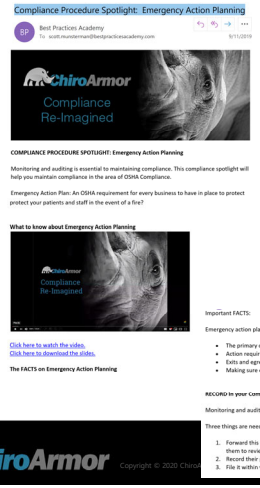
Compliance Procedure Spotlight: Emergency Action Planning

Best Practices Academy

ChiroArmor Compliance Re-Imagined

COMPLIANCE PROCEDURE SPOTLIGHT: Emergency Action Planning

Monitoring and auditing is essential to maintaining compliance. This compliance spotlight will help you maintain compliance in the area of OSHA Compliance.

Emergency Action Plan: An OSHA requirement for every business to have in place to protect protect your patients and staff in the event of a fire?

What to know about Emergency Action Planning

Click here to watch the video.
Click here to download the slides.

The FACTS on Emergency Action Planning

Important FACTS:

Emergency action planning addresses:

- The primary contact person for safety
- Action required prior to evacuation
- Exits and egresses clearly known and identified
- Making sure everyone is accounted for and meets in a central location

RECORD in your Compliance Manual

Monitoring and auditing is essential to maintaining compliance.

Three things are needed with this Compliance Spotlight:

1. Forward this Compliance Procedure Spotlight on to doctors and staff in your clinic for them to review,
2. Record their participation in your training log (download log), and
3. File it within your respective policy manual.

Compliance Spotlight

Monitoring and Auditing is Coordinated and Consistent to Policy

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What mandatory training is required for your practice each year?

33

HIPAA
OSHA
Fraud, Waste, Abuse

Coding and Documentation is strongly recommended by OIG/CMS

Some payers require cultural training

34

NSA

35

What is a "good faith estimate"?

Providers and facilities must furnish a good faith estimate of expected items and services beginning on or after January 1, 2022 which will allow uninsured (or self-pay) individuals to have access to information about health care pricing before receiving care.

This information will allow uninsured (or self-pay) individuals to evaluate options for receiving health care, make cost-conscious health care purchasing decisions, and reduce surprises in relation to their health care costs for items and services. Additionally, uninsured (or self-pay) individuals will need a good faith estimate to initiate the patient-provider dispute resolution process.

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Who is defined as an Uninsured or "Self-Pay" individual?

Does not have an insurance or health benefit plan (uninsured);

or

Does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal Health Care Program (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code[7],[8];

or

Has benefits for such items/services under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a health benefits plan under chapter 89 of title 5, United States Code, but does not seek to have a claim submitted to their plan, issuer, or carrier for the item or service.

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FAQS ABOUT CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION – GOOD FAITH ESTIMATES (GFE) FOR UNINSURED (OR SELF-PAY) INDIVIDUALS – PART 2

April 5, 2022

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ-Part-2.pdf

Timeframe "3 Day Rule"

Q5: Is a provider or facility required to provide a GFE to uninsured (or self-pay) individuals upon scheduling same-day (or walk-in) items or services?

A5: No. The requirement to provide a GFE to an uninsured (or self-pay) individual under 45 CFR 149.610 is not triggered upon scheduling an item or service if the item or service is being scheduled fewer than 3 business days before the date the item or service is expected to be furnished.

For example, if an uninsured (or self-pay) individual arrives to schedule same-day laboratory testing services, the laboratory testing provider or facility is not required to provide the individual with a GFE.

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If patient calls for an appointment and gets scheduled fewer than 3 days before appointment…

NO GFE REQUIRED

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"Substantially in Excess"

If the patient receives a bill which is $400 or more above the good faith estimate provided to them at the beginning of care, then the patient is eligible to proceed into a dispute resolution process with the provider (if initiated within 120 days of receiving the bill).

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Notice Requirements

Drafting the specific good faith notice of expected charges for each qualified patient.

Display the notice on clinic website.

Display in two prominent locations – where scheduling and payment occur.

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Practice Name
Location of Service: Practice Address

Provider Name
Provider NPI #
Provider TIN #

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call [INSERT PHONE NUMBER].

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OIG Work Plan and Documentation Requirements

Understanding how the oversight of the Office of Inspector General impacts your risk for claims audits and recoupment of payments.

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The OIG Workplan

Why should we care about what is on their workplan?

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OIG Work Plan and Semiannual Report

What does the OIG say we need to work on as a profession?

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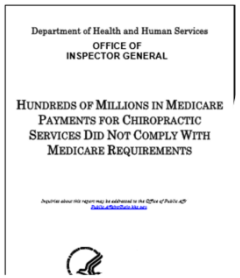
2015 Improper Payment Rate: 12.5%


Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

HUNDREDS OF MILLIONS IN MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES DID NOT COMPLY WITH MEDICARE REQUIREMENTS

In the 2016 OIG work report, chiropractic services had the highest rate of improper payments among Part B services*

*HUNDREDS OF MILLIONS IN MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES DID NOT COMPLY WITH MEDICARE REQUIREMENTS. Daniel R. Levinson Inspector General October 2016 A-09-14-02033. Public.Affairs@oig.hhs.gov.

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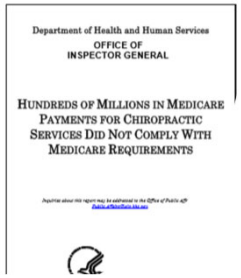
Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

HUNDREDS OF MILLIONS IN MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES DID NOT COMPLY WITH MEDICARE REQUIREMENTS

Chiropractic has risen to the top of the target list…

2016 OIG work report , chiropractic services had the highest rate of improper payments among Part B services estimated at $358.8 million, or approximately 82 percent.

Estimated overpayments for chiropractic services during the course of this time ranged from $257 million to $304 million.

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U.S. Department of Health and Human Services
Office of Inspector General

MEDICARE NEEDS BETTER CONTROLS TO PREVENT FRAUD, WASTE, AND ABUSE RELATED TO CHIROPRACTIC SERVICES

February 2018

An OIG Portfolio

A-09-16-02042

2018 OIG work report , chiropractic services had the highest rate of improper payment (from 2010 through 2015) ranging from 43.9 percent to 54.1 percent; compared with 9.9 percent to 12.9 percent average for all of Medicare's Part B services.

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2021 Improper Payment Rate: **6.26%**

2021 Medicare Fee-for-Service Supplemental Improper Payment Data report reflects chiropractic services had the second highest rate of improper payment at 33.7%, which represents $176,774,349 in improper payments.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

2021 Medicare Fee-for-Service Supplemental Improper Payment Data

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Appendix E: Improper Payment Rates and Type of Error by Type of Service for Each Claim Type

Appendix E tables are sorted in descending order by improper payment rate. For a full listing of all services with 30 or more claims, see Appendix G.

Table E1: Top 20 Service Type Improper Payment Rates: Part B

Part B Services (BETOS Codes)	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Other - non-Medicare fee schedule	51.2%	29.1% - 73.2%	0.0%	100.0%	0.0%	0.0%	0.0%	0.1%
Chiropractic	33.7%	24.7% - 42.7%	1.9%	86.8%	8.6%	2.7%	0.0%	0.7%
Standard imaging - other	28.5%	18.2% - 38.8%	0.0%	100.0%	0.0%	0.0%	0.0%	0.3%
Other tests - EKG monitoring	26.9%	6.2% - 47.7%	0.0%	100.0%	0.0%	0.0%	0.0%	0.5%
Specialist - other	25.5%	17.7% - 33.2%	3.4%	92.3%	0.0%	4.4%	0.0%	1.7%
Lab tests - other (non-Medicare fee schedule)	24.8%	19.6% - 30.1%	0.7%	88.8%	8.8%	0.0%	1.6%	3.2%

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Most common cause:

Improper payment rate for Medicare Part B chiropractic services included an 86.8% improper payment rate attributed to insufficient documentation and an 8.6% improper payment rate attributed to medical necessity errors

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"Despite these findings, CMS has not implemented or effectively implemented all of our recommendations, and controls over chiropractic services remain inadequate to prevent fraud, waste, and abuse."

Audits of chiropractic services… identified hundreds of millions of dollars in overpayments.

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"...the need for **better controls** over those services to protect the Medicare Trust Funds, **help reduce the risk of fraud**, and prevent beneficiaries from paying millions of dollars in coinsurance for chiropractic services that are not reasonable or necessary.

Further, chiropractic services that are not reasonable or necessary can **potentially harm** Medicare beneficiaries."

Overview of Medicare Program Vulnerabilities

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OIG Recommendations to CMS

CMS should:

1) work with its contractors to educate chiropractors on the training materials that are available to them;
2) educate beneficiaries on the types of chiropractic services that are covered by Medicare, inform them that massage and acupuncture services are not covered by Medicare, and encourage them to report to CMS chiropractors who are providing non-Medicare-covered services;
3) identify chiropractors with aberrant billing patterns or high service-denial rates, **select a statistically valid random sample of services** provided by each chiropractor identified, review the medical records for the sampled services, estimate the amount overpaid to each chiropractor, and **request that the chiropractors refund the amounts overpaid** by Medicare; and
4) establish a threshold for the number of chiropractic services beyond which medical review would be required for additional services.

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CMS Oversight

How is this oversight organized?

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CMS program to establish error rates and estimates of improper payments.

CERT evaluates a statistically valid random sample of claims to determine proper payment under Medicare coverage, coding and billing rules.

Monitors the work of the MACs.

Comprehensive Error Rate Testing Program (CERT)

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Medicare Administrative Contractors (MAC)

Error Rate Reduction Plan, LCDs, Provider Education

Recovery Audit Contractors (RAC)

Post Payment Claims Review

Appeals Process

Zone Program Integrity Contractors (ZPICS)

Probe Audits

Whistleblower

Hotline Complaints

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https://oig.hhs.gov/newsroom/whats-new/index.asp

Examples

OIG Workplan

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U.S. Department of Health and Human Services
Office of Inspector General

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Share this Report

Copies can also be obtained by contacting the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Twin Palms Received Unallowable Medicare Payments for Chiropractic Services

08-30-2019 | Audit (A-04-16-07065) | Complete Report | Report in Brief

Why OIG Did This Review

In calendar years (CYs) 2014 and 2015, Medicare allowed payments of approximately $1.3 billion for chiropractic services provided to Medicare beneficiaries nationwide. Previous OIG reviews found that Medicare inappropriately paid for chiropractic services that were medically unnecessary, incorrectly coded, or undocumented. After analyzing Medicare claims data, we selected for review Twin Palms Chiropractic Health Center, Inc. (Twin Palms), in Venice, Florida. Our analysis indicated that Twin Palms was among the top five chiropractors in Florida based on three Current Procedural Terminology codes billed to Medicare for chiropractic services.

https://oig.hhs.gov/oas/reports/region4/41607065.pdf

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Of the 100 sampled chiropractic services, 42 services were medically unnecessary. The results of the medical review indicated that these services did not meet one or more of the following Medicare requirements:

- Subluxation of the spine was not present or was not treated with manual manipulation or both (7 services).
- Manual manipulation of the spinal subluxation was maintenance therapy or was not appropriate for treatment of the patient's condition or both (26 services).
- Manual manipulation of the spinal subluxation would not be expected to result in improvement within a reasonable and generally predictable period (9 services).

For example, Twin Palms received payment for a chiropractic service provided to a 76-year-old Medicare beneficiary. The independent medical review contractor found that the medical records did not support the medical necessity of the service because none of the Medicare requirements listed above had been met. Further, the independent medical review contractor stated: "Absent detection of a subluxation on this date, no further improvement would be possible . . . . A reexamination was completed absent any report of subluxations . . . or manipulation . . . on this date . . . . The care was not medically necessary."

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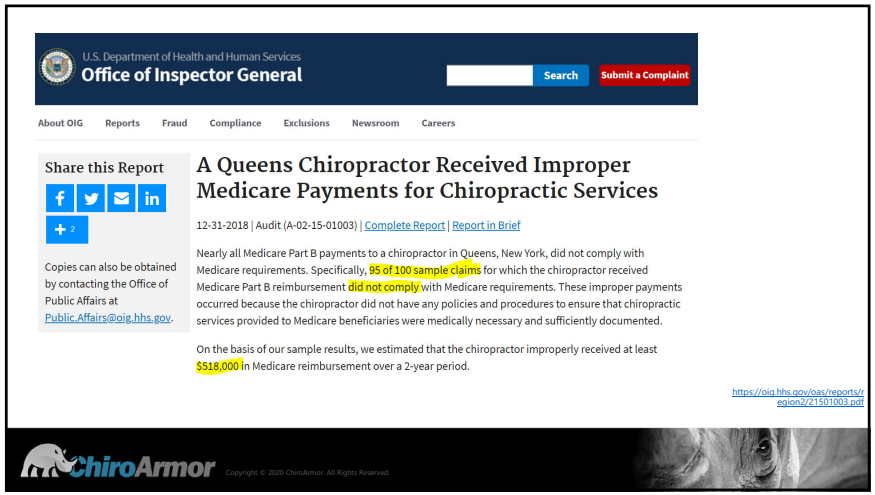
U.S. Department of Health and Human Services
Office of Inspector General
Search
Submit a Complaint
About OIG
Reports
Fraud
Compliance
Exclusions
Newsroom
Careers
Share this Report
Copies can also be obtained by contacting the Office of Public Affairs at Public.Affairs@oig.hhs.gov.
A Queens Chiropractor Received Improper Medicare Payments for Chiropractic Services
12-31-2018 | Audit (A-02-15-01003) | Complete Report | Report in Brief
Nearly all Medicare Part B payments to a chiropractor in Queens, New York, did not comply with Medicare requirements. Specifically, 95 of 100 sample claims for which the chiropractor received Medicare Part B reimbursement did not comply with Medicare requirements. These improper payments occurred because the chiropractor did not have any policies and procedures to ensure that chiropractic services provided to Medicare beneficiaries were medically necessary and sufficiently documented.
On the basis of our sample results, we estimated that the chiropractor improperly received at least $518,000 in Medicare reimbursement over a 2-year period.
https://oig.hhs.gov/oas/reports/region2/21501003.pdf
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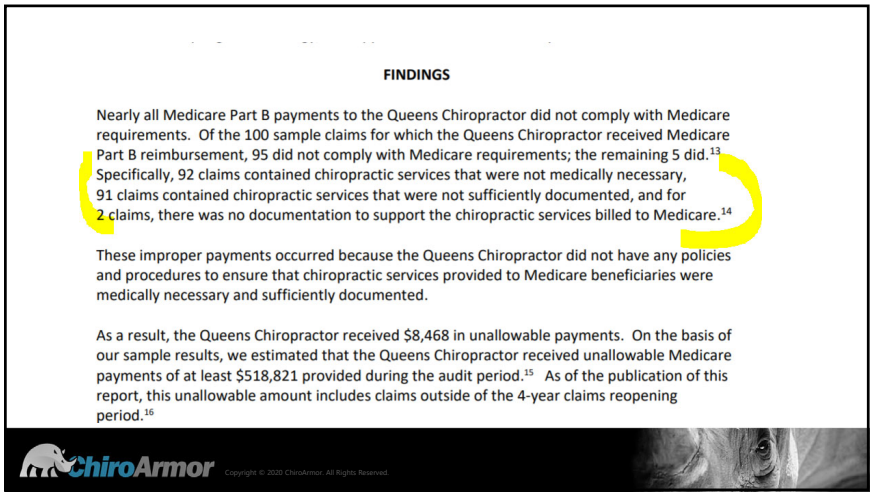
FINDINGS
Nearly all Medicare Part B payments to the Queens Chiropractor did not comply with Medicare requirements. Of the 100 sample claims for which the Queens Chiropractor received Medicare Part B reimbursement, 95 did not comply with Medicare requirements; the remaining 5 did.[13] Specifically, 92 claims contained chiropractic services that were not medically necessary, 91 claims contained chiropractic services that were not sufficiently documented, and for 2 claims, there was no documentation to support the chiropractic services billed to Medicare.[14]
These improper payments occurred because the Queens Chiropractor did not have any policies and procedures to ensure that chiropractic services provided to Medicare beneficiaries were medically necessary and sufficiently documented.
As a result, the Queens Chiropractor received $8,468 in unallowable payments. On the basis of our sample results, we estimated that the Queens Chiropractor received unallowable Medicare payments of at least $518,821 provided during the audit period.[15] As of the publication of this report, this unallowable amount includes claims outside of the 4-year claims reopening period.[16]
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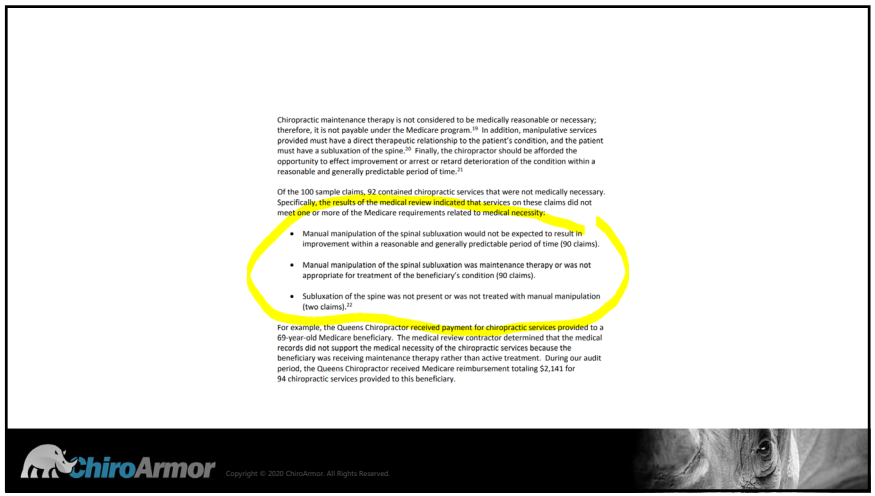
Chiropractic maintenance therapy is not considered to be medically reasonable or necessary; therefore, it is not payable under the Medicare program.[19] In addition, manipulative services provided must have a direct therapeutic relationship to the patient's condition, and the patient must have a subluxation of the spine.[20] Finally, the chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration of the condition within a reasonable and generally predictable period of time.[21]
Of the 100 sample claims, 92 contained chiropractic services that were not medically necessary. Specifically, the results of the medical review indicated that services on these claims did not meet one or more of the Medicare requirements related to medical necessity:
Manual manipulation of the spinal subluxation would not be expected to result in improvement within a reasonable and generally predictable period of time (90 claims).
Manual manipulation of the spinal subluxation was maintenance therapy or was not appropriate for treatment of the beneficiary's condition (90 claims).
Subluxation of the spine was not present or was not treated with manual manipulation (two claims).[22]
For example, the Queens Chiropractor received payment for chiropractic services provided to a 69-year-old Medicare beneficiary. The medical review contractor determined that the medical records did not support the medical necessity of the chiropractic services because the beneficiary was receiving maintenance therapy rather than active treatment. During our audit period, the Queens Chiropractor received Medicare reimbursement totaling $2,141 for 94 chiropractic services provided to this beneficiary.
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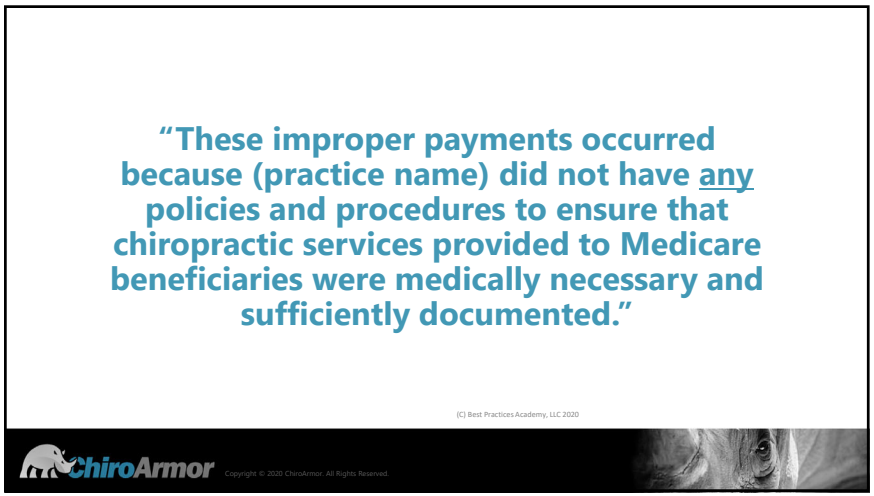
"These improper payments occurred because (practice name) did not have any policies and procedures to ensure that chiropractic services provided to Medicare beneficiaries were medically necessary and sufficiently documented."
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Medicare Compliance Risk

Key compliance issues…

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Areas of Risk:

- ✓Treatment Plan not provided
- ✓Mechanism of Trauma not identified
- ✓Subluxation not established
- ✓Changes since last visit not documented
- ✓Treatment Effectiveness not validated
- ✓Signature requirements not met
- ✓Scribes not identified
- ✓Someone other than the provider documenting the HPI and the exam
- ✓Medical necessity/Diagnosis coding issues
- ✓Cloning or other EMR issues
- ✓Incorrect category of E/M or CMT service billed
- ✓Improper use of modifiers/the need for a modifier not documented

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Cloning

- Very serious issue to CMS and OIG
- If your system allows you to bring forward documentation, you need to modify for the current information collected on the day of service.
- Need to identify information that is brought forward if not modified
- Initial exam and other data included in the documentation but performed on the date of service.

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CMS Comments

"Default documentation is a problem because it is difficult to tell what work was actually provided for the current visit."

"Medical necessity documentation is a cognitive process that is difficult to document with templates and macros."

"The volume of documentation should not influence the selection of the visit code."

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EHR templates are meant to prompt physician documentation.

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Erroneous, contradictory, or cloned information

Potential for fraud

Lack of medical necessity

Patient care issues

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Caution!!

Cloned notes may meet coding criteria but are not medically necessary if nothing changes from visit to visit.

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Policy Updates

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Quarterly Documentation Audit and Business Review

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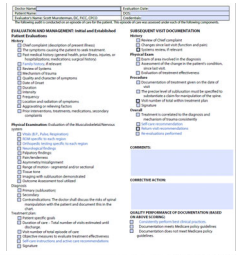
Documentation, Coding & Billing

Medicare and Medicaid



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ChiroArmor Dashboard

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The Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government.

False Claims Act

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Federal False Claims Act (FCA)

Examples of FCA in healthcare

- Falsifying a medical chart notation
- Submitting claims for services not performed, not requested, or unnecessary
- Submitting claims for expired drugs
- Upcoding and/or unbundling services
- Submitting claims for physician services performed by a non-physician provider (NPP) without regard to Incident-to-guidelines

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Federal False Claims Act (FCA)

The FCA 31 U.S.C. §§ 3729-3733

2-Types of healthcare conduct creating liability under the FCA

A. Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

B. Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

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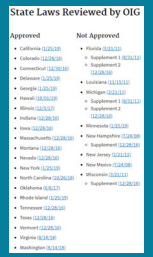
State False Claims Act Reviews


State Laws Reviewed by OIG

Approved

- California (1/29/19)
- Colorado (12/28/18)
- Connecticut (12/30/19)
- Delaware (1/29/19)
- Georgia (1/25/19)
- Hawaii (10/30/19)
- Illinois (12/3/17)
- Indiana (12/28/18)
- Iowa (12/28/18)
- Massachusetts (12/28/18)
- Montana (12/28/18)
- Nevada (12/28/18)
- New York (1/29/19)
- North Carolina (12/28/18)
- Oklahoma (6/6/17)
- Rhode Island (1/25/19)
- Tennessee (12/28/18)
- Texas (12/28/18)
- Vermont (12/28/18)
- Virginia (6/14/18)
- Washington (6/14/18)

Not Approved

- Florida (1/23/13)
  - Supplement 1 (6/21/13)
  - Supplement 2 (12/28/18)
- Louisiana (12/13/12)
- Michigan (12/21/12)
  - Supplement 1 (6/21/13)
  - Supplement 2 (12/28/18)
- Minnesota (1/25/19)
- New Hampshire (7/24/18)
  - Supplement (12/28/18)
- New Jersey (12/21/12)
- New Mexico (12/4/18)
- Wisconsin (12/21/12)
  - Supplement (12/28/18)

The Office of Inspector General (OIG), in consultation with the Attorney General, determines whether States have false claims acts that qualify for an incentive under section 1909 of the Social Security Act. Those States deemed to have qualifying laws receive a 10-percentage-point increase in their share of any amounts recovered under such laws.

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Stark Law

(Physician Self-Referral Law)

The Physician Self-Referral law (Stark Law), prohibits referring patients to receive "designated health services" from entities with which the physician or an immediate family member has a financial relationship, with a few exceptions

Designated Health Services (DHS)

- Clinical laboratory services
- Physical therapy services
- Occupational therapy services
- Radiology services
- Radiation therapy services
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetic and orthotic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

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Strict liability, no intent standard

Very complicated and should always consult with a healthcare attorney

Physician Self-Referral Law

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The Anti-Kickback Statute

42 U.S.C. § 1320 a-7b(b)

It is a felony to knowingly and willfully offer, pay, solicit, or receive anything of value in return for a referral, or to induce generation of business that is reimbursable under a federal healthcare program.

- Penalties
  - Fines up to $25,000 per violation
  - Up to a 5 year prison term per violation
  - False Claims Act Liability
  - CMP's

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The Anti-Kickback Statute

Inducements

- ✓ Waiving deductibles & co-pays
- ✓ Free Services
- ✓ Less than fair market value
- ✓ $15 per occurrence or $75 aggregately within a year (allowable gift to a patient)

Nice Doctors can equal Bad Doctors

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The term "induce" has been defined as follows: to bring on or about, to affect, cause, to influence to an act or course of conduct, lead by persuasion or reasoning, incite by motives, prevail on.

Black's Law Dictionary, 697 (6th ed. 1990).

Inducement

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Questions to ask yourself…

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Does my documentation demonstrate medical necessity and do I have accurate coding and billing of my claims?

False Claims Act

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Does the business arrangement involve offering, paying, soliciting, or receiving any renumeration (i.e., anything of value) to induce or reward referrals of items or services reimbursable by a federal health care program?

Stark Law

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Does the arrangement involve giving something of value to a Medicare or Medicaid beneficiary that will likely influence the beneficiary's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicare or a state health care program, including Medicaid?

Anti-Kickback

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Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five years, or both.

Conviction will also lead to automatic exclusion from Federal health care programs, including Medicare and Medicaid.

Violation of Anti-Kickback

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Anti-Kickback Statute

Prohibits:

- Knowingly and willfully soliciting, receiving, offering or paying (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or in part under a federal health care program (which includes the Medicare program).
- Fine of up to $25,000, imprisonment up to five (5) years, or both fine and imprisonment

42 United States Code §1320a-7b(b)

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The Office of Inspector General's List of Excluded Individuals/Entities (LEIE)

Individuals and entities currently excluded from participation in Medicare, Medicaid, and all other Federal health care programs

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Exclusion Statute

42 U.S.C. § 1320a-7

Mandatory—conviction of program related crimes, patient abuse, healthcare fraud, etc.

Permissive—implemented for reasons as conviction to obstruction of an investigation or audit, license revocation or suspension, fraud, kickbacks, and other prohibited activities.

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Exclusion Statute

Length of Exclusion

✓Not less than 5-years

✓Certain factors can lengthen the period of exclusion

When the exclusion period has ended, the individual or entity must apply for reinstatement.

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Exclusion Statute

Important to check:

✓New Hires

✓Staff/Doctors: Every 30 days

http://oig.hhs.gov/exclusions/exclusions_list.asp.

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