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.

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.

Why is Quality Documentation of my Patient Records important?

Reasons:

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

Jurisprudence Review

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https://www.menti.com/al279v8824a

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Public Policy Influences Chiropractic Care

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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Clinical Standard of Care

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

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What is deemed as the Chiropractic Standard of Care?

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.

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.

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

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

Understanding Key Concepts

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What do you think are the most common documentation errors that can result in recoupment?

Most Common Documentation Errors

Mechanism of Onset/Trauma not established
Treatment Plan not completed correctly
Lack of documenting changes since the last visit
Default documentation (cloned notes)
Improper coding
Lack of correct documentation per code requirements
Lack of completing/signing notes in timely manner

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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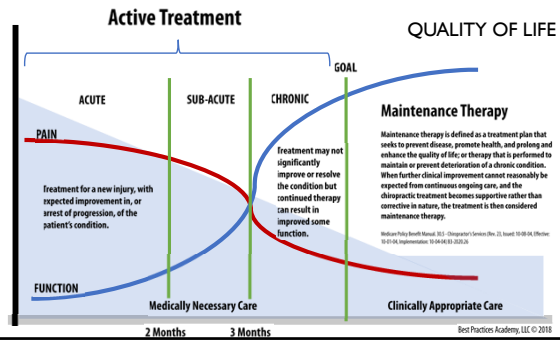

Initial Visit

History
Examination
Clinical Decision Making

Initial Visit Documentation Requirements

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

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

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

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.*

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

Determining Causation

Mechanism of Trauma
Insidious Onset
Time Lapse of Treatment

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.

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

How should you document this?
Insidious onset?
Cause unknown?

Common Area of Non-Compliance

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

What other factors are involved?

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

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

Six in 10 Americans have delayed seeking medical attention…

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

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?

Fill the gap!

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

ROS

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

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

Past Family Medical Social History (PFMSH)

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.

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.

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.

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!

Outcome Assessment Tools

Physical and Behavioral

Examination

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

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**?

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

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)

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

Pain Assessment through Examination

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.

Medical Decision Making

Arriving at a diagnosis and Treatment Plan involves using Decision Support Tools, Critical Thinking Processes, and an Evidence-informed Approach.

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?

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.

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)

Predictive Analysis

Differential Diagnosis

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.

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)

Report of Findings

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

Opportunities for Education

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!

Report of Findings

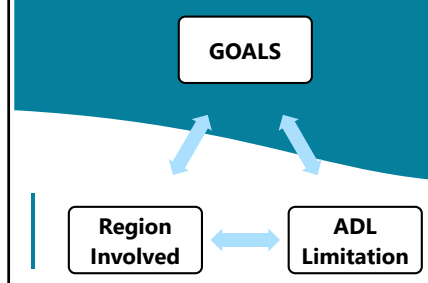
- You are not selling the patient on care. You are a clinician delivering the facts.
- You are to be friendly, but you are not there to be their friend. Stay unbiased and objective.
- Report to the patient within the context of tissue involvement and healing response times. (i.e., muscle 2-4 weeks, bone 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)

Treatment Plan

Treatment Plan

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

Treatment Plan Triangulation



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.

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

Specific measurable goals are benchmarked… and measured for performance.

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Goal Selection

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

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.

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

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

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

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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

Tissue Differentiation

Healing Timeframes
Tension versus Compression Biomechanics

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Barriers to Care

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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!

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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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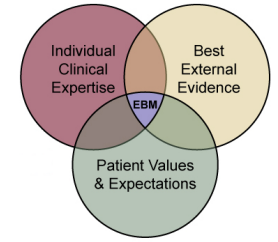
Evidence-based Practice



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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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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https://www.menti.com/al279x9842ex

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E/M Visit Coding

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.*

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.

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.

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.

99211

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

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)

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

Medical Decision Making

(the clinical thought process)

Differential Diagnosis

Treatment plan:

- ✓Goals
- ✓Duration
- ✓Frequency

Differential Diagnosis

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

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

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

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.

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.

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.

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.

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.

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

Straightforward
99202/99212

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

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

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

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

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

How much clinical data did we need to process?

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

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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

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

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

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**

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

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.

Tables of Risk

Evaluation and Management Service Guide, ICN 006764 January 2020 CMS 1142-01 Booklet

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf

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

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

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

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.)

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

Straightforward
99202/99212

Minimal risk of morbidity from additional diagnostic testing or treatment.

Low
99203/99213

Low risk of morbidity from additional diagnostic testing or treatment.

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

High
99205/99215

High risk of morbidity from additional diagnostic testing or treatment

Examples:

Drug therapy requiring monitoring

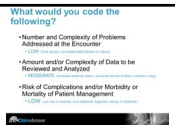
Surgery with patient risk factors

Emergency procedures/hospitalizations

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

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.)

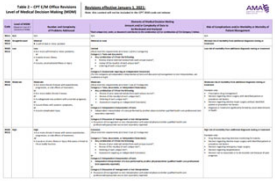


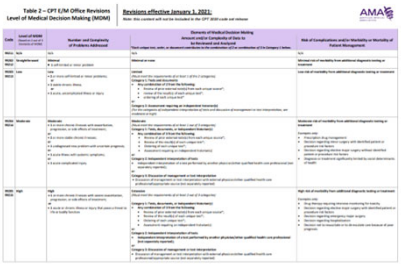
Low
99203/99213

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.

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





"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

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

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.

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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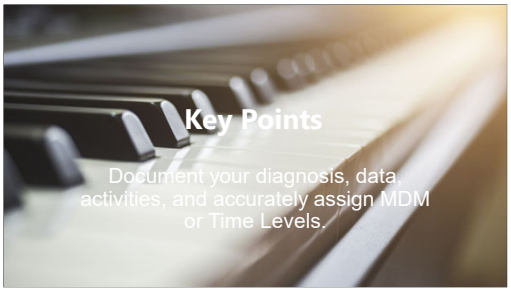

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Financial Analysis

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

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

Under-Coding or Discounting E/M visits

Both are considered Inducement

Documentation Self-Audit

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?		

Subsequent Visit

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13-18

https://www.menti.com/al279v8824a

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

Subsequent Visits

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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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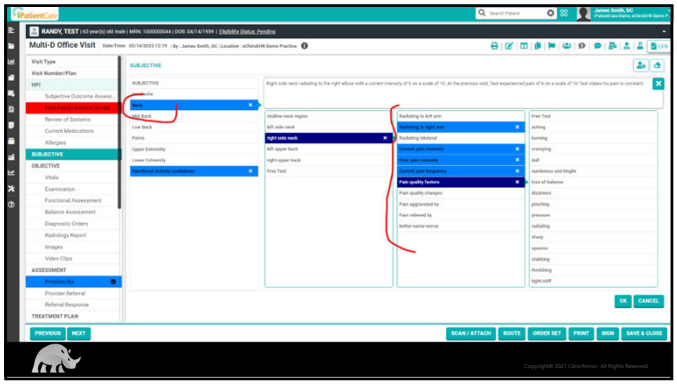

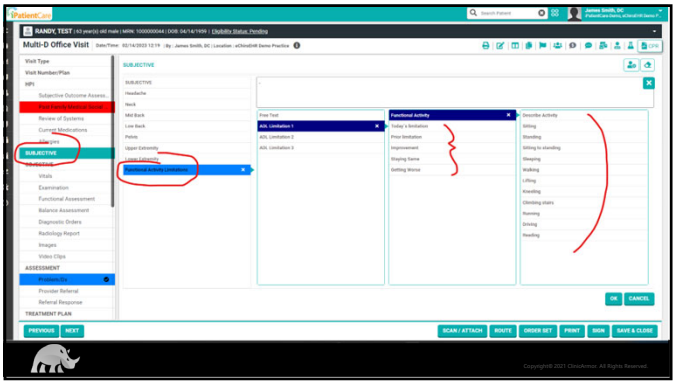

Common Area of Non-Compliance

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."

EHR templates are meant to prompt physician documentation.

Caution!!

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

Erroneous, contradictory, or cloned information

Potential for fraud
Lack of medical necessity
Patient care issues

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.

"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

How do we demonstrate treatment effectiveness?

Quantify and Measure

Update Subjective Pain Intensity and Function on Each Visit

Common Area of Non-Compliance

Subjective Changes since the last visit…

- Pain Level using VAS
- Aggravating Factors
- ADL Limitation

Update Objective Findings

When palpation reveals changes since the last visit…

- Palpatory findings
- ROM
- Ortho findings, etc.

Objective Changes since the last visit…

How do we demonstrate treatment effectiveness?

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Treatment Visit Coding

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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

209

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

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

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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…

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Use of 9894X Codes and 97140

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.

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.

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Common Documentation Error

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

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…

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.

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

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).

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.

Verbal Cues

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

Visual Cues

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

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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.

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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.

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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.

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Pressure Cues

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

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Stretching Cues

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

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Tension Cues

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

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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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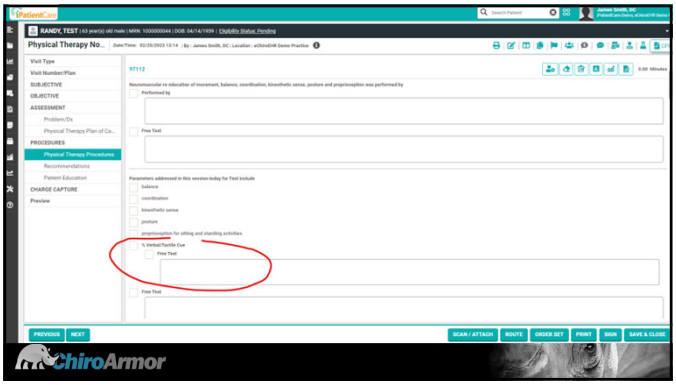

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Therapeutic Activities

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.

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.

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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

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.

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

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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."

Most Common Documentation Errors Recap

Mechanism of Onset/Trauma not established
Treatment Plan not completed correctly
Lack of documenting changes since the last visit
Default documentation (cloned notes)
Improper coding
Lack of correct documentation per code requirements
Lack of completing/signing notes in timely manner

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 [98940] 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?		

Progress Evaluations

Discharge from care when goals have been achieved.

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

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Document Progress against the Goals

Progress Evaluations every 12 visits or 30 days

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?

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.

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

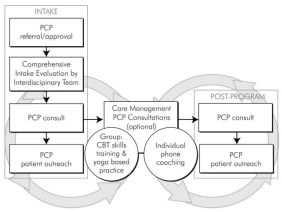

Fig. 2. PPACT intervention description.

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

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.

4. Document your referral in the patient's chart

5. Track the referral to close the loop.

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

Other Common Considerations in Documenting a Patient's Care Journey

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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.

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?

Self-directed care is considered Maintenance Therapy

ABN must be provided

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**."

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.

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.

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.

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

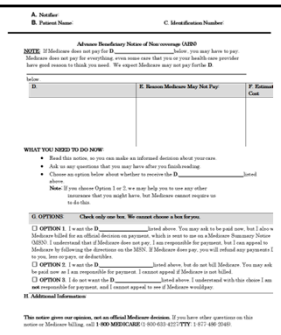
- The patient is asked to sign a blank form.
- ABN is used routinely without regard to particularized need.
- The Medicare approved waiver is not the actual waiver signed by the patient.
- Approved waiver has been altered beyond what is allowed by CMS.

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.

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 Non-coverage (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.

D.	E. Reason Medicare May Not Pay:	F. Estimated 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).

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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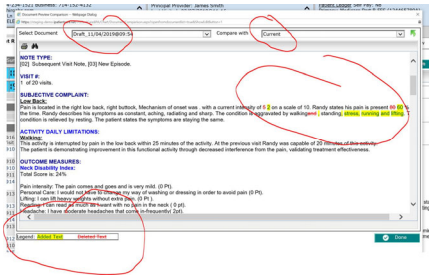

Note Amendment: Tracking Changes

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Questions or Comments?

Thank you!!

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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!

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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/

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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

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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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