NAILING MEDICAL NECESSITY AND AVOIDING AUDITS

Presented by Evan M. Gwilliam, DC MBA
CPC CCPC QMCC CPMA CPCO AAPC Fellow

PRACTISYNC
Bridging Efficiency, Empowering Success

Evan.Gwilliam@Practisync.com

1

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2

3

Take Away

- Discover who gets picked on
- Use the chain of medical necessity
- Create rock solid care plans
- Identify what payers are looking for

4

AUDIT TARGETS

5

Take Away

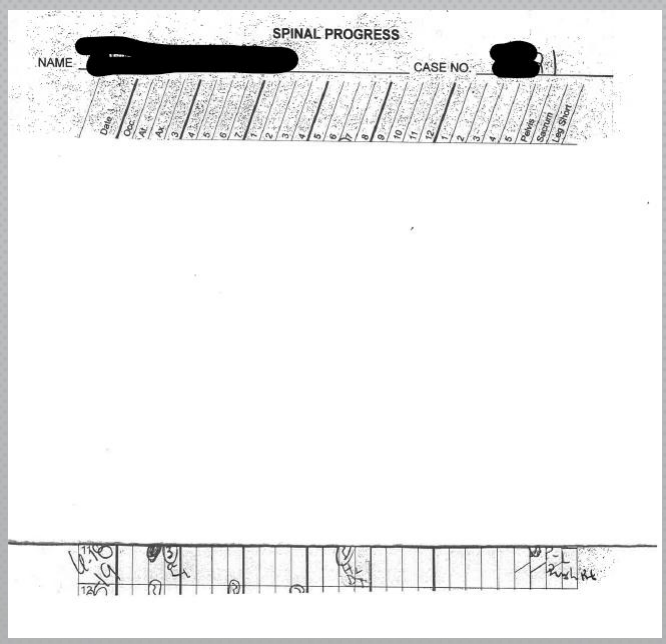
- What is the #1 reason for improper payments to chiropractors?
- How do they pick who to audit?

6

palpation of shoulders noted adhesions and crepitations upon movement. Left hip noted crepitations and mms spasms of the left hip flexors upon movement on the patient by the doctor with grade 2 pain noted by the patient.

Segment C1 was found to be subluxated on the right with moderate reduced motion. Motion palpation revealed vertebral levels C6, T1, and T2 was subluxated on the left with a mild degree of aberrant motion. Motion palpation showed moderate restriction of joint function on the left affecting levels T5 and T6. Vertebral segment subluxation was revealed at T8 on the left with mild reduced motion. Palpation examination of the cervical region, the thoracic region, and the lumbar region elicited a moderate level of muscle spasms bilaterally. Subluxation was revealed at C5 on the right with moderate fixation. The patient's Biceps Reflex returned a response of normal on the left. During the examination of the patient, the Biceps Reflex was elicited to be normal on the right. Her Brachiordalis Reflex was normal on the right. Normal results were obtained from the Brachiordalis Reflex on the left. The Triceps Reflex was found to be normal on the left. Jackie's Triceps Reflex was revealed to be normal on the right. On the left Jackie's Achilles Reflex was found to be normal. This patient's Achilles Reflex on the right was normal. This patient's Patellar Reflex was found to be active and equal on the right. Upon examination of this patient, the Patellar Reflex was elicited to be active and equal on the left. Her Heel-Toe Test was not able to be performed due to physical limitation. Her Lasegue Sign generated a result of negative. This patient's Foraminal Compression Test was revealed to be positive. A response of positive on both sides was given by the Shoulder Depr. Test. Jackie's Valsalva Maneuver/Test was unable to be performed due to physical limitation with low back and left leg pain. Adson's Sign was positive on both sides. Bechterew's Sitting Test was unable to be performed due to physical limitation with low back and left leg pain. Braggard's Sign elicited a result of negative on both sides. Ely's Sign was positive on both sides. Kemp's Test was positive with low back and left leg pain. The patient's Nachlas Test indicated a response of positive on both sides. Well Leg Raise Test (Fajersztajn's) was positive on the left. Yeoman's Test was noted to be positive on both sides. A result of negative was given by Goldwaite's Sign. Palpation examination of the upper thoracic region noted a moderate measure of muscle spasms bilaterally. Moderate muscle spasms at the right shoulder were elicited upon palpatory examination. Palpatory examination of the patient noted moderate muscle spasms at the left shoulder. Palpatory examination of the patient found moderate muscle spasms at the full region cervical region bilaterally. Palpatory examination revealed moderate muscle spasms at the lumbosacral lumbar region bilaterally. Her cervical rotation on the left was 60 ° with decreased motion and moderate pain. This patient's cervical rotation was revealed to be 60 ° with decreased motion and moderate pain on the right. The cervical lateral flexion was found to be 25 ° with decreased motion and mild pain on the right. The patient's cervical lateral flexion on the left was 25 ° with decreased motion and mild pain. Jackie's cervical spine extension was elicited to be 30 ° with decreased motion and moderate pain. During my examination of this patient, the cervical spine flexion was revealed to be 30 ° with decreased motion and moderate pain. Palpatory examination of the patient found moderate muscle spasms at both shoulder. Muscle spasms at the left hip were noted to be moderate upon palpatory examination. Palpation of the patient elicited moderate muscle spasms at the full region lumbar region bilaterally. A test at the T2 dermatome on the right noted to be normal. A sensation test at the L2 dermatome on the right noted to be normal. A test presented normal findings on the right at the L4 dermatomal level. Sensation at the L4 dermatomal level on the left noted to be normal. Sensation at the L5 dermatomal level on the left noted to be normal. A sensation test at the L5 dermatomal level on the right noted to be normal. Palpation elicited moderate pain at the left hip. This patient's hip abduction on the left was 30 ° with decreased motion and moderate pain. Jackie's hip adduction on the left was 22.5 ° with normal motion and moderate pain. On the left Jackie's hip extension was found to be 7.5 ° with normal motion and moderate pain. The hip flexion was 90 ° with decreased motion and moderate pain on the left. This patient's hip external rotation was 25 ° with normal motion and moderate pain on the left. Her hip internal rotation was found to be 40 ° with normal motion and mild pain on the left. The shoulder abduction on the left was 180 ° with normal motion and mild pain. This patient's shoulder adduction was 180 ° with normal motion and mild pain on the right. On the left this patient's shoulder adduction was elicited to be 50 ° with normal motion and mild pain. Jackie's shoulder extension was noted to be 50 ° with normal motion and mild pain on the left. This patient's shoulder extension on the right was 40 ° with normal motion and moderate pain. Upon examination of

7



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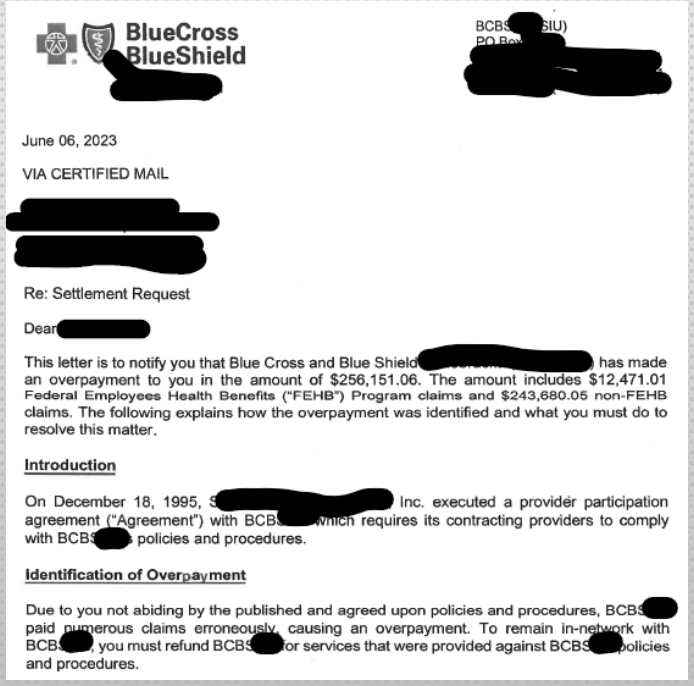


BlueCross BlueShield

[redacted]

June 06, 2023

VIA CERTIFIED MAIL

[redacted]

Re: Settlement Request

Dear [redacted]

This letter is to notify you that Blue Cross and Blue Shield [redacted] has made an overpayment to you in the amount of $256,151.06. The amount includes $12,471.01 Federal Employees Health Benefits ("FEHB") Program claims and $243,680.05 non-FEHB claims. The following explains how the overpayment was identified and what you must do to resolve this matter.

Introduction

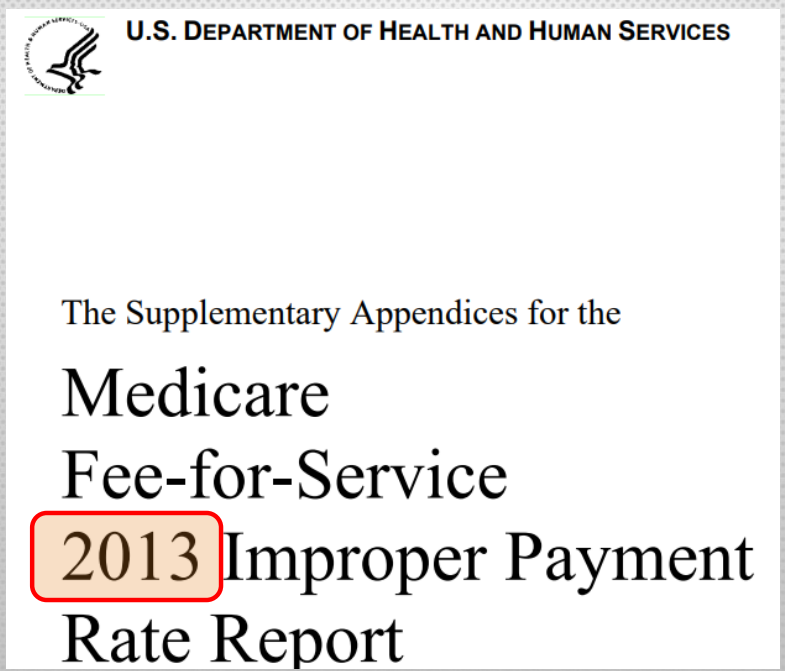
On December 18, 1995, [redacted] Inc. executed a provider participation agreement ("Agreement") with BCBS [redacted] which requires its contracting providers to comply with BCBS [redacted] policies and procedures.

Identification of Overpayment

Due to you not abiding by the published and agreed upon policies and procedures, BCBS [redacted] paid numerous claims erroneously, causing an overpayment. To remain in-network with BCBS [redacted], you must refund BCBS [redacted] for services that were provided against BCBS [redacted] policies and procedures.

9

9



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Supplementary Appendices for the

Medicare Fee-for-Service 2013 Improper Payment Rate Report

10

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

Appendix C tables are sorted in descending order by improper payment rate. Some columns and/or rows may not sum correctly due to rounding.

Table C1: Top 20 Service Type Improper Payment Rates: Part B

Service Type Billed to Part B (BETOS codes)	Improper Payment Rate	95% Confidence Interval	Type of Error				
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other
Chiropractic	51.7%	46.1% - 57.4%	1.5%	92.5%	4.5%	0.6%	0.8%
Hospital visit - initial	28.3%	26.0% - 30.6%	2.0%	21.7%	0.0%	75.9%	0.4%
Lab tests - other (non-Medicare fee schedule)	26.1%	20.2% - 32.0%	0.4%	98.4%	1.1%	0.0%	0.0%
Hospital visit - critical care	22.9%	17.8% - 28.0%	3.2%	49.2%	0.0%	47.6%	0.0%
Specialist - psychiatry	21.5%	15.7% - 27.2%	2.1%	95.3%	0.0%	2.2%	0.4%

11

11

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

2018 Medicare Fee-for-Service Supplemental Improper Payment Data

12

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

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

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

Part B Services (BETOS Codes)	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Consultations	84.2%	78.3% - 90.1%	3.4%	48.8%	0.0%	0.9%	47.0%	0.0%
Home visit	41.6%	22.7% - 60.6%	1.5%	92.7%	0.0%	5.8%	0.0%	0.3%
Chiropractic	41.0%	34.5% - 47.5%	0.0%	88.3%	7.7%	4.0%	0.0%	0.8%
Other - non-Medicare fee schedule	30.5%	11.6% - 49.3%	10.4%	88.1%	0.0%	0.0%	1.5%	0.1%
Lab tests - other (non-Medicare fee schedule)	29.8%	25.7% - 33.9%	0.6%	93.7%	4.7%	0.0%	1.0%	3.0%

13

13

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

2022 Medicare Fee-for-Service Supplemental Improper Payment Data

14

14

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

Appendix E tables are sorted in descending order by improper payment rate. All estimates in these tables are based on a minimum of 30 lines in the sample. For a full listing of all services with 30 or more claims, see Appendix G.

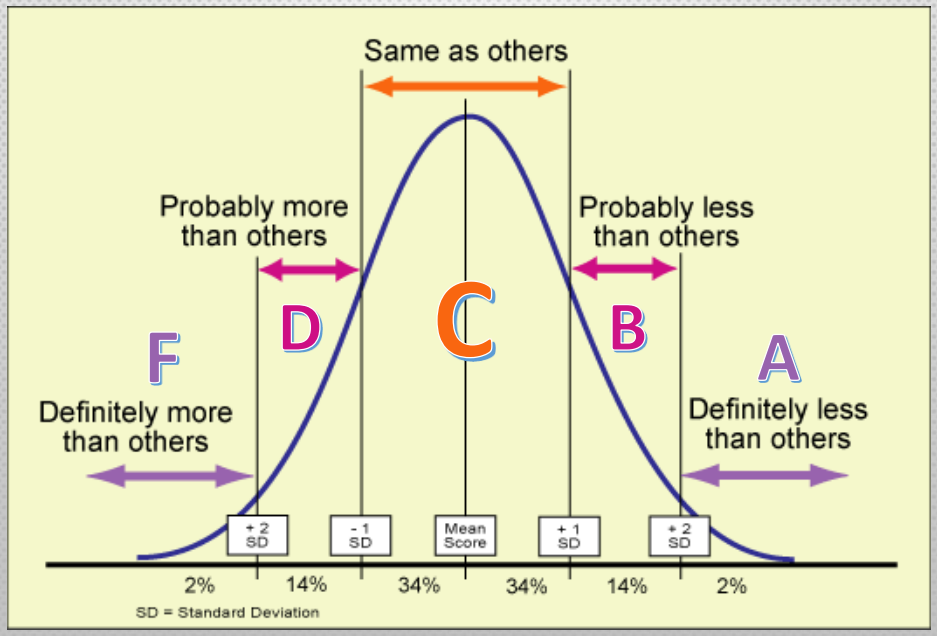
Table E1: Top 20 Service Type Improper Payment Rates: Part B

Part B Services (BETOS Codes)	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Other - non-Medicare fee schedule	42.5%	22.9% - 62.0%	0.0%	98.0%	0.5%	0.4%	1.1%	0.1%
Chiropractic	31.3%	24.3% - 38.3%	2.3%	88.5%	4.1%	3.8%	1.2%	0.5%
Lab tests - other (non-Medicare fee schedule)	26.4%	21.8% - 31.1%	3.8%	91.2%	0.1%	0.0%	4.9%	3.7%
Lab tests - bacterial cultures	26.2%	5.8% - 46.6%	0.0%	100.0%	0.0%	0.0%	0.0%	0.1%
Specialist - other	24.5%	17.6% - 31.4%	3.2%	80.8%	0.0%	3.0%	13.1%	1.9%
Ambulatory [illegible]	23.0%	10.4% - 35.6%	7.4%	90.8%	0.3%	0.0%	1.6%	0.8%

15

15

Who is selected for an audit?



16

17

SPECIAL INVESTIGATIONS DEPARTMENT

BlueCross BlueShield [redacted]

June 7, 2021

[redacted]

Dear Provider,

Blue Cross and Blue Shield [redacted] (BCBS[redacted]), periodically conducts reviews of claims submitted by providers as part of our commitment to improving our members' access to quality and affordable health care. We are providing you the following information to help you ensure your billing best reflects the services you provide to BCBS[redacted] members.

Your practice was identified as an outlier (above one standard deviation from the mean[1]) for claims submitted to BCBSIL during dates of service March 1, 2020, through February 28, 2021, for

[1] Approximately 68%, 95% and 99.7% of the providers fall within one, two and three standard deviations of the mean, respectively.

18

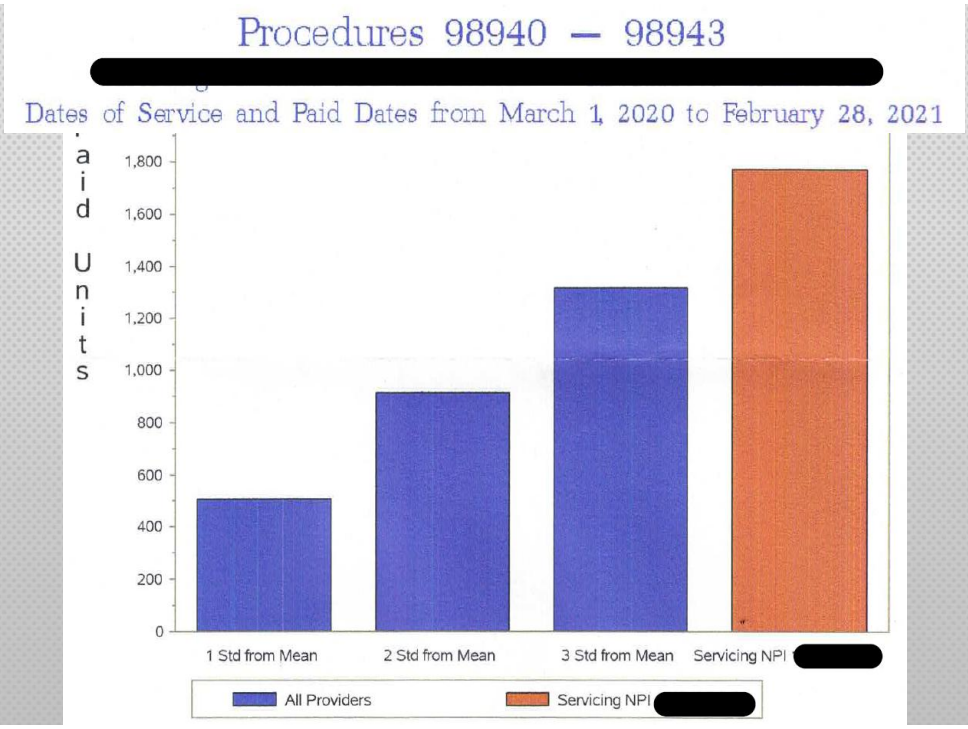
In short, the medical necessity for manipulation of the region must be evidenced in your documentation, and claims where medical necessity is not supported by required documentation are not reimburseable. Accordingly, even absent a request from us, the records you maintain for our members must satisfy these requirements and support the medical necessity of the billed services and as a condition to any reimbursement.

In connection with this letter, the Special Investigations Department is including a graph that compares your billing of CPT codes 98940 through 98943 with others billing these codes.

BCBS relies on the accuracy and completeness of claims that you and other providers submit to accurately process claims for benefits under health plans that it insures or administers. While we are providing you information with respect to your billing, BCBS may request medical records for a more thorough review of any particular claim or claims and take additional action including, but not limited to, issuing a refund request if it discovers overpayments based on the incorrect coding of services billed and/or lack of required documentation. As part of this letter, BCBS is not asking for any medical records or making any refund requests regarding your billing of these codes. BCBS continues to rely on you to ensure all your claims are correctly coded and otherwise true, accurate, and complete when submitted to BCBS

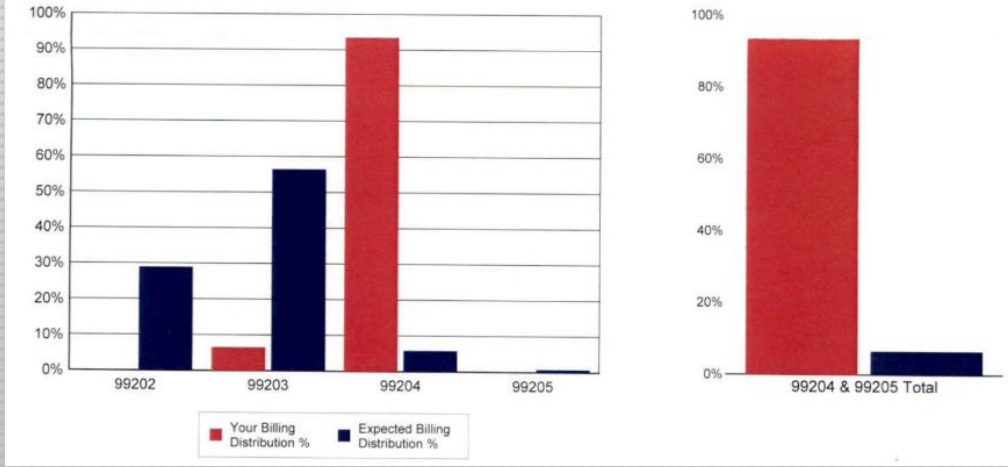
We hope that the information reflected in this notice is helpful and informative. If you have any questions about this Notice or BCBS billing procedures, please contac

19



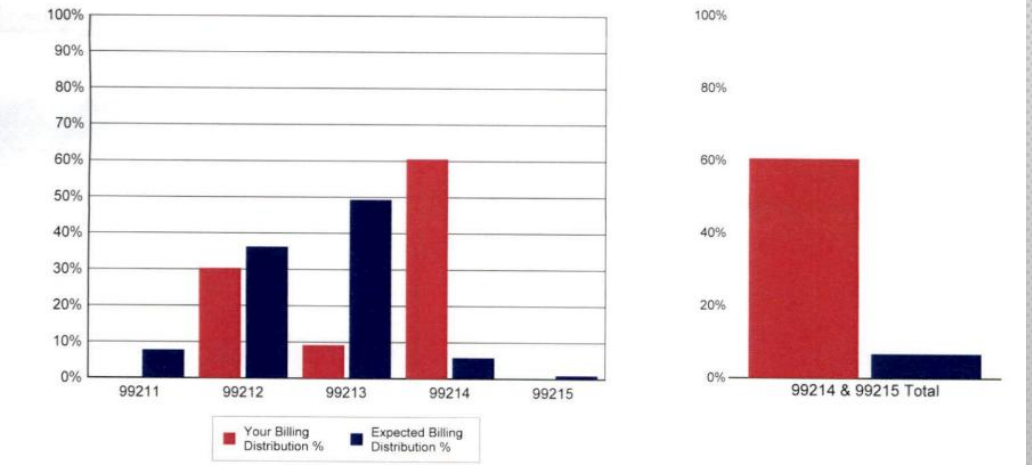
20

Procedure Code Range	99202	99203	99204	99205
Your Billing Distribution[1]	0	3	43	0
Your Billing Distribution %	0.0%	6.5%	93.5%	0.0%
Expected Billing Distribution %[2]	28.9%	56.4%	5.9%	0.7%



21

Procedure Code Range	99211	99212	99213	99214	99215
Your Billing Distribution[1]	0	33	10	66	0
Your Billing Distribution %	0.0%	30.3%	9.2%	60.6%	0.0%
Expected Billing Distribution %[2]	7.7%	36.2%	49.3%	5.8%	1.0%



22

RELI Group
7125 Ambassador Drive, Suite 100
Windsor Mill, MD 21244

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

[redacted]
Chiropractic Manipulative Treatment (CMT) of the Spine
[redacted]

January 31, 2022

[redacted]

Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. To support these goals, CMS has contracted with the RELI Group to develop this Comparative Billing Report (CBR) and to support providers with its use.

23

Comparative Billing Report (CBR) 202201
January 31, 2022

Chiropractic Manipulative Treatment (CMT) of the Spine

Introduction

CBR202201 focuses on rendering providers with specialty 35 (chiropractic) that submitted claims to Medicare Part B for CMT of the spine. The analysis will focus on Current Procedural Terminology® (CPT®) codes 98940, 98941, and 98942, as well as modifier AT (Acute Treatment). For the purposes of this document and analysis, these CPT® codes will be referred to as "CMT of the spine."

The CBR analysis was based on claims extracted from the Integrated Data Repository, based on the latest version of claims available on Dec. 6, 2021. The analysis includes claims with dates of service from Jan.1, 2019, through Dec. 31, 2019. For the trend analysis presented in Figure 1 and Figure 2, claims represent dates of service between Jan. 1, 2017, and Dec. 31, 2019.

The *2021 Medicare Fee-for-Service Supplemental Improper Payment Data* report reflects an improper payment rate of 33.7% for chiropractic services, which represents $176,774,349 in improper payments. The types of error that comprise the improper payment rate for Medicare Part B chiropractic services include an 86.8% improper payment rate attributed to insufficient documentation and an 8.6% improper payment rate attributed to medical necessity errors. After review of and research into the improper payment rate, this CBR was created to analyze the possible threat associated with chiropractic services to the Medicare Trust Fund. The expectation is that providers that perform CMT will maintain proper documentation and appropriate use of modifier AT.

24

In the *2021 HCPCS Level II Expert* the definition for modifier AT is: "append this modifier with specific chiropractic manipulative treatment, or CMT, spinal codes when the provider performs treatment of the acute or chronic spinal subluxation." The explanation for the modifier reads as follows: "The provider uses modifier AT with chiropractic manipulative treatment codes such as 98940 to 98942 to indicate the acute or active nature of treatment. The patient's medical records should also support the active nature of chiropractic treatment in that the record should reflect the anticipated result of the chiropractic manipulation is either an improvement in, or a complete arrest of the progression, of the patient's condition."

The criteria for receiving a CBR are that a provider:

1. Is significantly higher compared to either state or national percentages in any of the three metric calculations (i.e., greater than or equal to the 95th percentile), and
2. Has at least 60 beneficiaries with claims submitted for CMT of the spine, and
3. Has at least $20,000 in total charges for CMT of the spine.

Coverage and Documentation Overview

Table 1 identifies the CPT® codes used in the CBR analysis.

Table 1: CPT® Code Descriptions

CPT® Codes	Description
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions

25

Table 2 provides summaries of your utilization of CPT® codes for CMT of the spine.

Table 2: Summary of Your Utilization of CPT® Codes for CMT of the Spine Between Jan. 1, 2019, and Dec. 31, 2019

CPT® Codes	Allowed Charges	Allowed Units	Beneficiary Count
98940 Without Modifier AT	$0	0	0
98940 With Modifier AT	$39,521	1,397	168
98941 Without Modifier AT	$0	0	0
98941 With Modifier AT	$34,640	842	144
98942 Without Modifier AT	$0	0	0
98942 With Modifier AT	$0	0	0
Total	$74,161	2,239	224

*A beneficiary is counted once per row of CPT® code level. The total "Beneficiary Count" is not the sum total; it represents unique beneficiaries for all the CPT® codes for the 12-month period.

Metrics

This report is an analysis of the following metrics:

1. Average allowed services per beneficiary
2. Percentage of CMT of the Spine billed with CPT® code 98942
3. Percentage of claims billed with modifier AT

26

Methods and Results

There are 42,813 rendering providers nationwide that have submitted claims for CMT of the spine. The total allowed charges for these claims were over $768,261,546 during the analysis timeframe.

$768,261,546 / 42,813 = $17,944 per rendering provider

Metric 1: Average Allowed Services per Beneficiary

Metric 1 is calculated as follows:

- The total number of allowed services for CMT of the spine is divided by the number of unique beneficiaries who received CMT of the spine.

Table 3: Average Allowed Services per Beneficiary

Numerator	Denominator	Your Average	Your State Average	Comparison with Your State	National Average	Comparison with National Average
2,239	224	10.00	6.89	Higher	9.05	Higher

27

Table 4: Percentage of CMT of the Spine Billed with CPT® Code 98942

Numerator	Denominator	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
0	2,239	0.00%	3.47%	Does Not Exceed	4.79%	Does Not Exceed

Metric 3: Percentage of Claims Billed with Modifier AT

Metric 3 is calculated as follows:

- The total number of unique claims for CMT of the spine billed with modifier AT is divided by the total number of unique claims for all CMT of the spine.

Table 5: Percentage of Claims Billed with Modifier AT

Numerator	Denominator	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
2,239	2,239	100.00%	100.00%	Significantly Higher	100.00%	Significantly Higher

Figures 1 and 2 illustrate the trend over time analysis for the number of beneficiaries who had claims submitted

28

Take Away

- What is the #1 reason for improper payments to chiropractors?
- How do they pick who to audit?

29

AUDIT TARGETS

30

OIG

31

Take Away

- What does the Office of the Inspector General find problematic in chiropractic offices?
- What can we do about it?

32

Office of the Inspector General

Mission:
The Office of Inspector General's (OIG) mission is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries.

Since 1976, the OIG has focused on fighting fraud and abuse in Medicare and Medicaid

33

Office of the Inspector General

- Has 1600 employees conducting audits, investigations, and evaluations
- Makes cost saving or policy recommendations to decision makers and the public
- Helps develop cases for criminal and civil and administrative enforcement
- Educates the public about fraudulent schemes so they can protect themselves and report suspicious activities

34

Office of the Inspector General

A search on the OIG web site reveals that fourteen reports about chiropractic have been released since 2005.

Report in Brief
Date: August 2019
Report No. A-04-16-07065

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Why OIG Did This Review
In calendar years (CYs) 2014 and 2015, Medicare allowed payments of approximately $1.3 billion for chiropractic services provided to Medicare beneficiaries nationwide.

Twin Palms Received Unallowable Medicare Payments for Chiropractic Services

What OIG Found
Some chiropractic services that Twin Palms billed were not allowable in

35

June 2005: Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis

Findings:

- 67% error rate (2001 claims), mostly due to maintenance visits
- $285 million in improper payments
- 94% of bad claims lacked supporting documentation
- >12 visits usually lack medical necessity

Recommendations:

- CMS should do more reviews of documentation, focusing on all visits in an episode
- CMS should educate chiropractors on documentation requirements

36

May 2009: Inappropriate Medicare Payments for Chiropractic Services

Findings:

- 47% error rate (2006 claims)
- $178 million inappropriately paid
- Chiros use AT modifier inappropriately with maintenance visits
- Only half of treatment episodes remained active/corrective, especially after the 20th visit.
- 83% of claims failed to meet documentation requirements

Recommendations:

- Create a new modifier to indicate start of an episode
- Implement a cap on number of visits
- CMS should review complete episodes, especially when more than 12 visits
- CMS should only pay if documentation requirements are met.

37

November 2013: Diep Chiropractic Wellness, Inc. Received Unallowable Medicare Payments for Chiropractic Services

Findings:

- 93 of 100 sampled services were not allowable
- 70 were medically unnecessary (maintenance)
- 11 were incorrectly coded
- The rest were not documented correctly
- 82% were billed as 98942

Recommendations:

- Pay back $708,022 of the $879,658 that was paid in 2010 and 2011
- Establish policies and procedures to correctly document and code for services billed to CMS

38

May 2015:
Advanced Chiropractic Services Received Unallowable Medicare Payments for Chiropractic Services

Findings:

- All of the 105 service line items reviewed did not support medical necessity.
- 98942 was billed 98% of the time.
- One patient received 273 services over two years

Recommendations:

- ACS should pay back $369,335, and maybe $737,111
- Establish policies and procedures to correctly document services billed to CMS

39

July 2015:
Alleviate Wellness Center Received Unallowable Medicare Payments for Chiropractic Services

Findings:

- 100 of 100 sampled services were not allowable
  - 56 were medically unnecessary (maintenance)
  - 23 were insufficiently documented
  - 21 were not documented
  - 84% were billed as 98941

Recommendations:

- Pay back $482,867 to the Federal Government
- Establish policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary and adequately documented

40

September 2015:
CMS Should Use Targeted Tactics to Curb Questionable and Inappropriate Payments for Chiropractic Services

Findings:
- In 2013, $76 million in Medicare payments to chiros were questionable
- Half were maintenance
- 2% of chiropractors were responsible for the questionable payments

Recommendations:
- CMS should figure out a better way to identify maintenance care and questionable payments
- CMS should go after chiropractors with questionable payments
- CMS should collect overpayments
- CMS should only pay for Medicare-covered diagnoses

41

August 2016:
A Michigan Chiropractor Received Unallowable Medicare Payments for Chiropractic Services

Findings:
- Of 100 sampled services, 92 were not allowable.
- Records did not support medical necessity
- 98942 was billed 93% of the time

Recommendations:
- Refund $339,625 to the Federal Government
- Establish policies and procedures to ensure that chiropractic services billed to Medicare are adequately documented

42

October 2016:
Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply with Medicare Requirements

Findings:

- Of the 105 sampled services, 94 were not allowable because they were medically unnecessary (maintenance)
  - 1-12 services: 26 of 35 medically unnecessary
  - 13-30 services: 33 of 35 medically unnecessary
  - 31+ services: 35 of 35 medically unnecessary

Recommendations:

- CMS should set a limit and review all services above that number
- CMS should not pay for services above some set limit
- CMS should educate chiropractors about what is covered
- CMS should set more controls like limiting the number of days

43

August 2017:
A Brooklyn Chiropractor Received Unallowable Medicare Payments for Chiropractic Services

Findings:

- Of 100 sampled services, none were allowable.
- 78% were billed 98941, 22% 98942.

Recommendations:

- Refund $672,805 to the Federal Government
- Identify other overpayments outside the audit period (2011 and 2012) and pay them back too.

44

February 2018:
Medicare Needs Better Controls to Prevent Fraud, Waste, and Abuse Related to Chiropractic Services

Portfolio Highlights:

- Medicare still makes hundreds of millions in improper payments
- CMS controls are inadequate

Recommendations:

- CMS should set a review threshold for medically unnecessary services

45

July 2018:
Medicare Improperly Paid Providers for Items and Services offered by Chiropractors

Portfolio Highlights:

- From 2013 to 2016 Medicare made $6.7 million in overpayments to chiropractors

Recommendations:

- CMS should recover the $6.7 million
- CMS should get providers to investigate themselves to pay back more
- CMS should revise claims edits to ensure that all claims are denied

46

September 2018:
Etheridge Chiropractor Received Unallowable Medicare Payments for Chiropractic Services

Findings:

- Of 100 sampled services, 33 were not allowable
- 82% were billed 98941

Recommendations:

- Refund $169,737 to the Federal Government
- Identify other overpayments outside the audit period and pay them back too
- Establish policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary and adequately documented

47

December 2018:
Queens Chiropractor Received Unallowable Medicare Payments for Chiropractic Services

Findings:

- Of 100 sampled services, 95 did not comply with CMS requirements
- 98% were billed 98940

Recommendations:

- Refund $518,821 to the Federal Government
- Identify other overpayments outside the audit period and pay them back too
- Establish policies and procedures to ensure that chiropractic services billed to Medicare comply with CMS requirements

48

August 2019:
Twin Palms
Received Unallowable Medicare Payments for Chiropractic Services

Findings:

- Of 100 sampled services, 54 were not allowable
  - 42 were medically unnecessary (maintenance)
  - 11 were insufficiently documented
- 82% were billed 98941

Recommendations:

- Refund $317,038 to the Federal Government
- Establish policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, adequately documented, and coded correctly

49

Lessons learned

- Don’t bill 98942 unless you meet the criteria
- Document the services rendered as CMS has outlined
- Don’t bill CMS for services that are defined as maintenance care
- Clearly outline an episode of care
- Be prepared for extra scrutiny beyond 12 visits

Learn the “Chain of Medical Necessity”

50

Other Common Errors

- Illegible records
- Missing dates
- Missing signature
- Missing informed consent
- Missing re-assessment
- Missing patient identifiers
- Missing metrics/objective
- Blanks used to indicate "WNL"
- Missing legend for abbreviations
- Missing care plan
- Cloned records
- Billing only 98940 or only 98941
- Using travel cards

51

Take Away

- What does the Office of the Inspector General find problematic in chiropractic offices?
- What can we do about it?

52

OIG

53

MEDICAL NECESSITY

54

Take Away

- Apply the Chain of Medical necessity in your office
- Tell the whole story in your records

55

Are your records a weakness that can be exploited?

Or are they a suit of armor that protect you from liability and failed audits?

56

57

Medical Necessity

- Services or items reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member"

–Centers for Medicare and Medicaid Services

How can you prove medical necessity?

58

Chain of Medical Necessity

→History of onset
→Patient complaint
→Exam findings
→Diagnosis
→Treatment plan
→Functional Progress

59

Chain of Medical Necessity

History of onset→

- Outline why the patient has a complaint
- If an acute condition:
  - Document date and mechanism of trauma
- If a chronic condition:
  - Try to establish why the patient decided to come in today, rather than another time

60

Chain of Medical Necessity

Patient Complaint→

- Must be consistent with onset
- Can outline functional loss (walking, sleep)
- Compensatory regions?

61

Chain of Medical Necessity

Exam Findings→

- Must relate to the complaint
- Should not be filled with fluff
- Can provide an explanation for the functional loss

62

Chain of Medical Necessity

Diagnosis→

- Should provide a plausible explanation for the symptoms
- Should match up with the clinical criteria from the complaint and exam

63

Chain of Medical Necessity

Treatment Plan→

- Should be appropriate for the diagnosis
- Should not be given just because of:
  - provider technique
  - philosophy
  - a routine
- Should transition from passive to active
- Should not be cookie cutter (but templates are okay)

64

Chain of Medical Necessity

Functional Progress→

- Goals should be:
  - specific to each patient
  - Measurable/quantifiable
- Outcomes Assessment Tools are the best way to quantify functional progress
- Goals must be evaluated and updated over time

65

Chain of Medical Necessity

→History of onset
→Patient complaint
→Exam findings
→Diagnosis
→Treatment plan
→Functional Progress

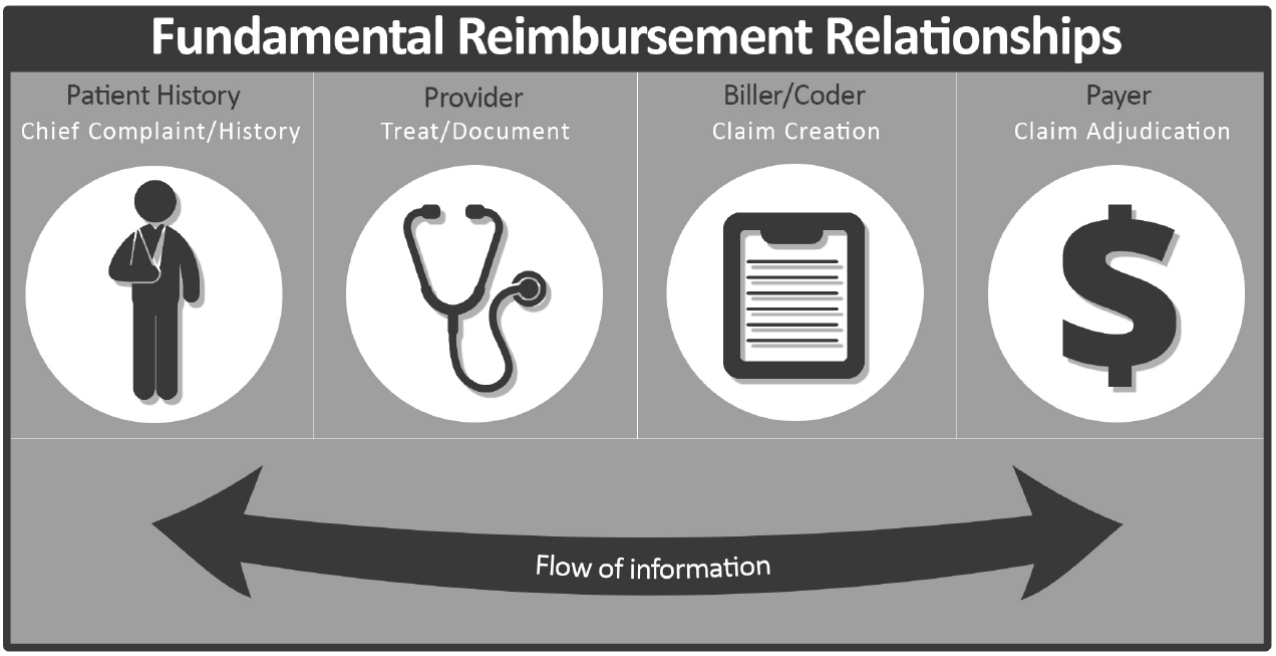
66

Documentation

- Outlines a clear course of care and the patient's response to treatment
- Provides clear evidence of continuity of care to communicate with other providers
- Acts as a legal record of the care given
- Allows comparisons between differing patient episodes as well as other patients with similar conditions
- Supports the billing for services rendered

67

Figure 4.1



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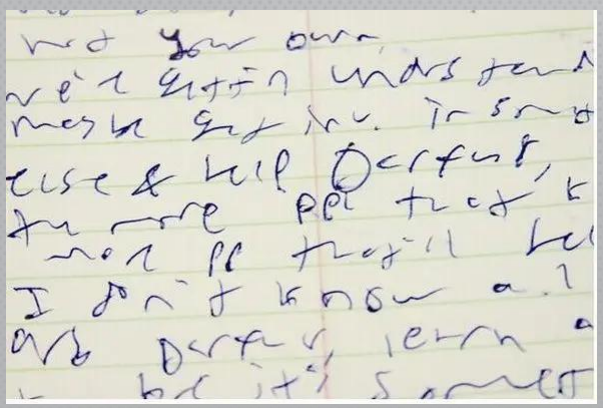

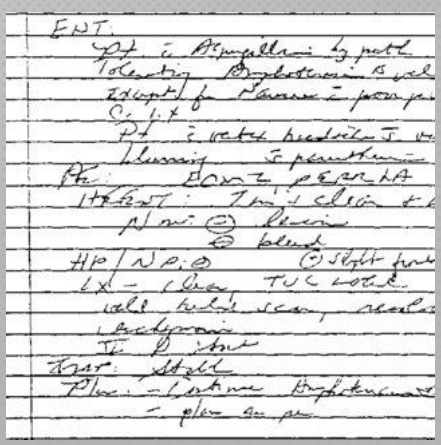

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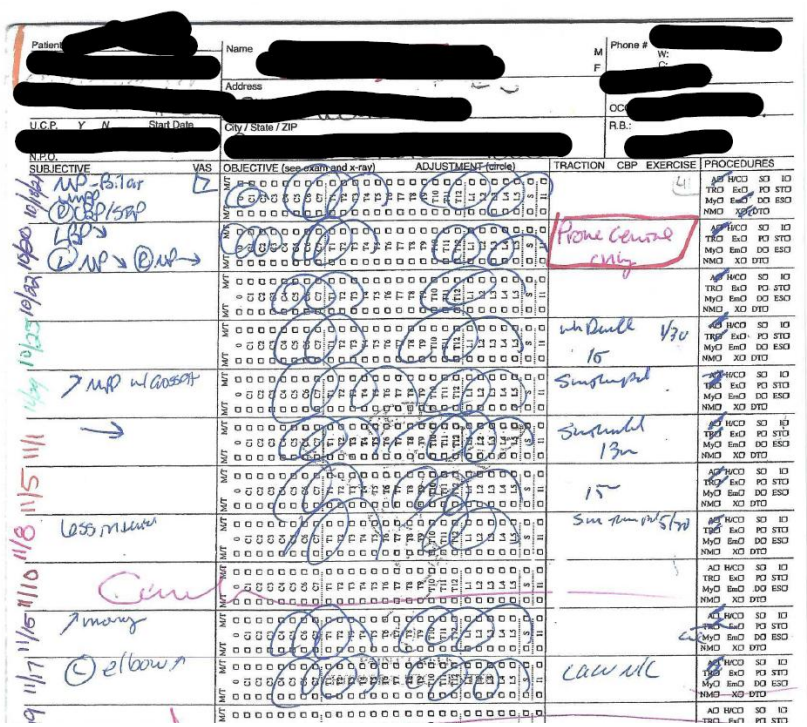


71

Take Away

- Apply the Chain of Medical necessity in your office
- Tell the whole story in your records

72

MEDICAL NECESSITY

73

CARE PLANS

74

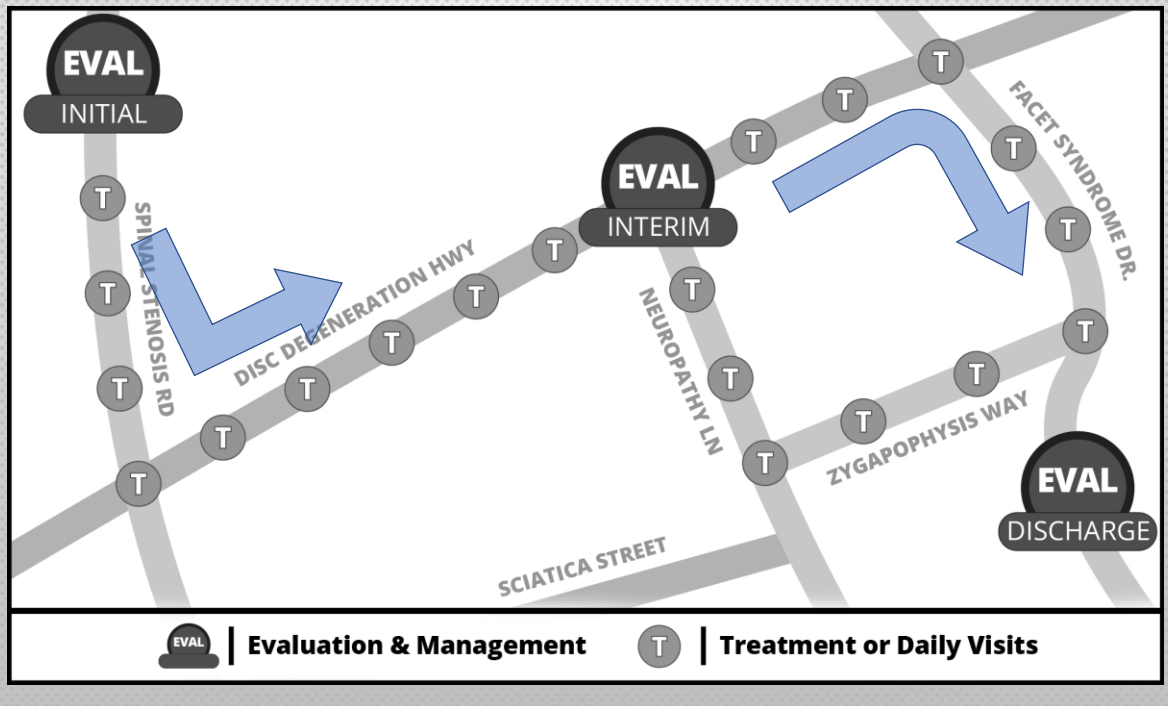
Take Away

- Learn the essential pieces of a care plan
- Use evidence-based guidelines
- Create goals that establish medical necessity

75

Road Trip

76



77

Why Is A Care Plan Important?

Required by:

- Medicare
- Private payers
- State statutes / board of examiners

- Patients deserve them

- It shows you have gone through the decision-making process

78

Medicare Care Plans

Treatment Plan

- ☐ Frequency and duration of visits (recommended)
- ☐ Specific treatment goals (recommended)
- ☐ Objective measures to evaluate treatment effectiveness (recommended)

79

MLN1232664 Medicare Documentation Job Aid for Chiropractic, March 2022

79

Utilization Review Guidelines

(From a Carriers Perspective)

80

Passive Care

- The patient is not actively involved
- The patient is acted upon
- Designed more for pain relief
- Long term passive care can be detrimental

Examples:
Ice/Heat, Bracing, Ultrasound, Electrical Stimulation, Traction, Manual Therapies, CMT, etc.

81

Active Care

- The patient is an active participant in the activity
- Includes education and exercise
- Designed towards long-term outcomes

Examples:
Muscle strengthening, stretching, cardiovascular fitness, balance and coordination, e.g. physioball, balance boards, flexbars, Therabands, water therapy, treadmill, etc.

82

Elements of a Care Plan

All physical medicine services should fall within a physical medicine therapeutic plan. The components should include the **goal** of treatment, documentation of the original **limitation**, what will be **measured** to assess progress, initial **baseline** performance levels and how the services will help the patient achieve the goal. During the course of treatment the patient's **progress** compared to goal should be documented, as well as instructions for the patient regarding how to sustain progress i**ndependent**ly.

-Blue Cross Commercial Provider Manual-2025, Documentation Guidelines for Physicians, page 23

83

Elements of a Care Plan

1. Diagnostic statement
2. Specific procedures w/ rationale for each
3. Frequency (times per week)
4. Duration (# of weeks)
5. Long term functional goals
6. Stages or phases of care (benchmarks)

84

Stages of Care

Phase One (Relief) - Treatment provided is to alleviate **pain** and is directed to limit the extent of the injury or condition, reduce signs and symptoms of **inflammation**, and to minimize functional disability. The **short-term** use of adjunctive therapeutic **modalities**/procedures may be appropriate in addition to manipulative procedures. If significant improvement in the patient's pain and functional ability is not achieved in the **first two weeks** of care, alternative treatment options should be explored.

-Horizon BCBS Chiropractic Review Policy #162

85

85

Stages of Care

Phase Two (Therapeutic) - Treatment provided is directed to focus on improving pain-free **ranges of motion** and restoration of **function** to the fullest extent possible, promoting structural integrity and **avoid de-conditioning**. Frequency of treatment and use of therapeutic according to member progress and care should transition from **passive to active** treatments.

86

-Horizon BCBS Chiropractic Review Policy #162

86

Stages of Care

Phase Three (Rehabilitative) - Treatment provided is directed to focus on promoting the restoration of **strength**, **endurance** and performance of **activities necessary for daily living**.

-Horizon BCBS Chiropractic Review Policy #162

87

87

Sample Care Plan

CARE PLAN DETAILS

Based on the findings, it is anticipated that there will be 3 stages of care: Phase One (relief), Phase Two (therapeutic), and Phase Three (rehabilitative).

During the **Phase One (relief) stage**, the following services are expected to be provided:

- 98941 - CMT 3-4 Regions consisting of diversified technique, Gonstead technique, and Thompson technique will be performed to the neck, back, and pelvis, specifically to the cervical vertebrae, lumbar vertebrae, thoracic vertebrae, to increase pain free range of motion by 50% and reduce pain reported by 50%. This will be provided 3 times per week for 4 weeks.
- 97014 - Electrical Stimulation-2 consisting of Russian stim will be performed to the neck, back, specifically to the upper trapezius, lower trapezius, to reduce severity of palpable muscle spasm. This will be provided 3 times per week for 4 weeks.
- 97010 - Ice/Heat consisting of ice pack will be performed to the neck, to reduce pain reported by 50%. This will be provided 3 times per week for 2 weeks.
- 99213 Re-evaluations will be performed once every 4 weeks.

If further therapeutic benefit is anticipated, then, during the **Phase Two (therapeutic) stage**, the following services are expected to be provided:

- 98941 - CMT 3-4 Regions consisting of diversified technique, Gonstead technique, and Thompson technique will be performed to the neck, back, and pelvis, specifically to the cervical vertebrae, lumbar vertebrae, thoracic vertebrae, to increase pain free range of motion by 75% and reduce pain reported by 75%. This will be provided 2 times per week for 4 weeks.
- 97110 - Therapeutic Exercise (Ea. 15 Min) consisting of 6 way cervical stretch, cervical/shoulder towel stretch, Cervical neck glides, and Cat/camel stretch will be performed to the neck, to increase pain free range of motion by 75% and improve posture. 1 unit will be provided 2 times per week for 4 weeks.
- 97140 - Manual Therapy (Ea 15 Min) consisting of active release and trigger point therapy will be performed to the neck, specifically to the sternocleidomastoid, levator scapulae, suboccipitals, to break-up adhesions. 1 unit will be provided 2 times per week for 4 weeks.
- 99212 Re-evaluations will be performed once every 4 weeks.

If further therapeutic benefit is anticipated, then, during the **Phase Three (rehabilitative) stage**, the following

88

88

Duration of Treatment

"Duration and frequency of treatment is variable and is based on the severity and type of the injury/condition, functional limitations, as well as the resolution of the condition or attainment of maximum medical improvement."

- Horizon BCBS

89

89

Duration of Treatment

Short term

- M54.50 *low back pain, unspecified*
- M54.2 *cervicalgia*

Moderate term

- M43.16 *spondylolisthesis, lumbar region*
- M47.23 *other spondylosis with radiculopathy, cervicothoracic region*
- M54.12 *radiculopathy, cervical region*
- M62.830 *muscle spasm of back*
- M79.18 *myalgia, other site*
- S16.1xxA *strain of muscle, fascia and tendon at neck level, initial encounter*

Long term

- M48.061 *spinal stenosis, lumbar region without neurogenic claudication*
- M54.31 *sciatica, left side*
- M51.371 *other intervertebral disc degeneration, lumbosacral region with lower extremity pain only*

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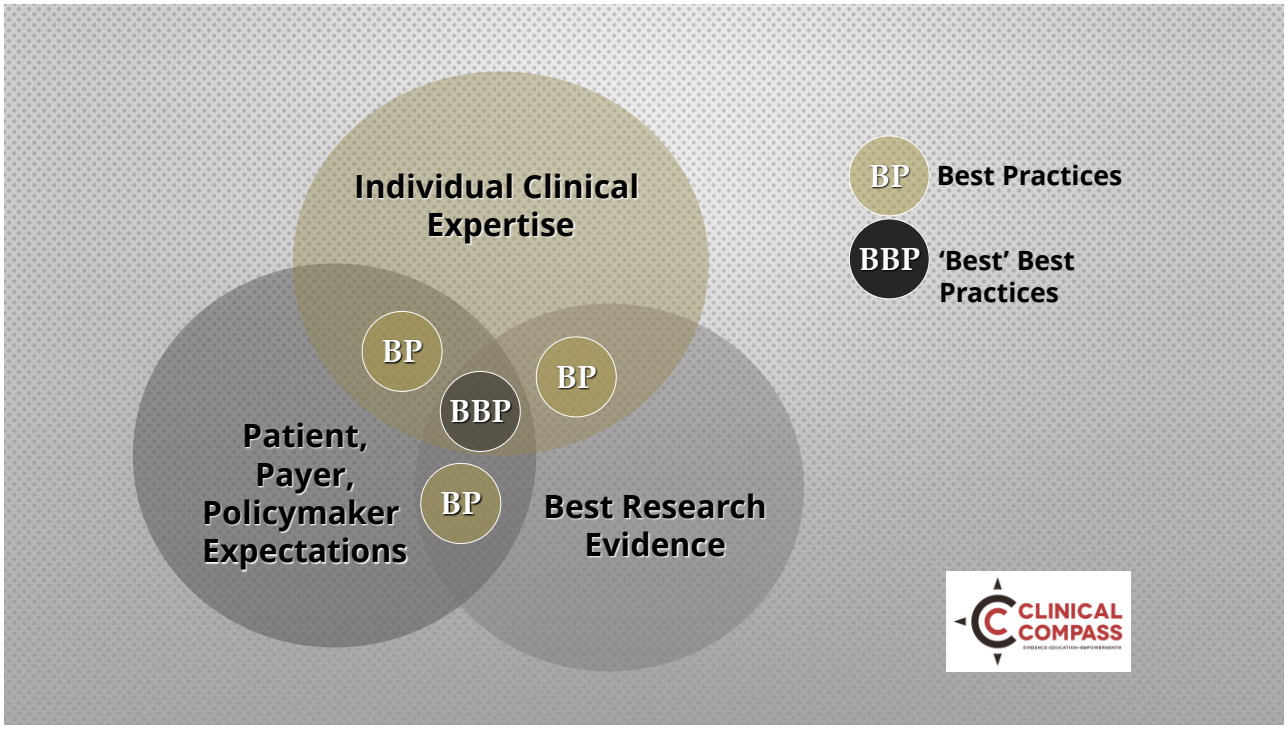
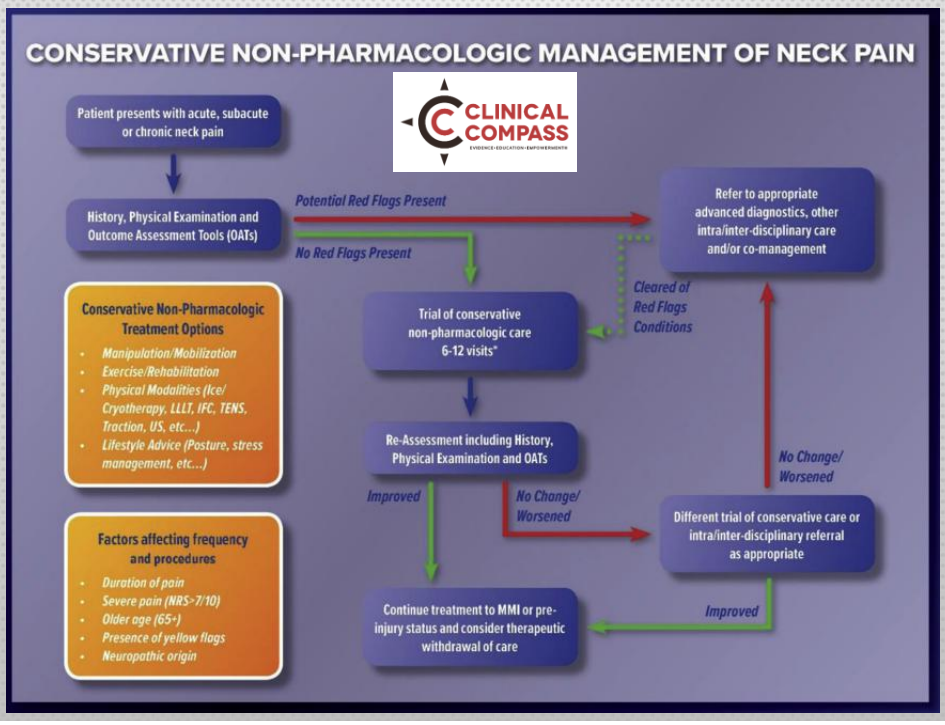


93

Best-Practice Recommendations for Chiropractic Management of Patients With Neck Pain
J Manipulative Physiol Ther. 2019; Whalen et al.



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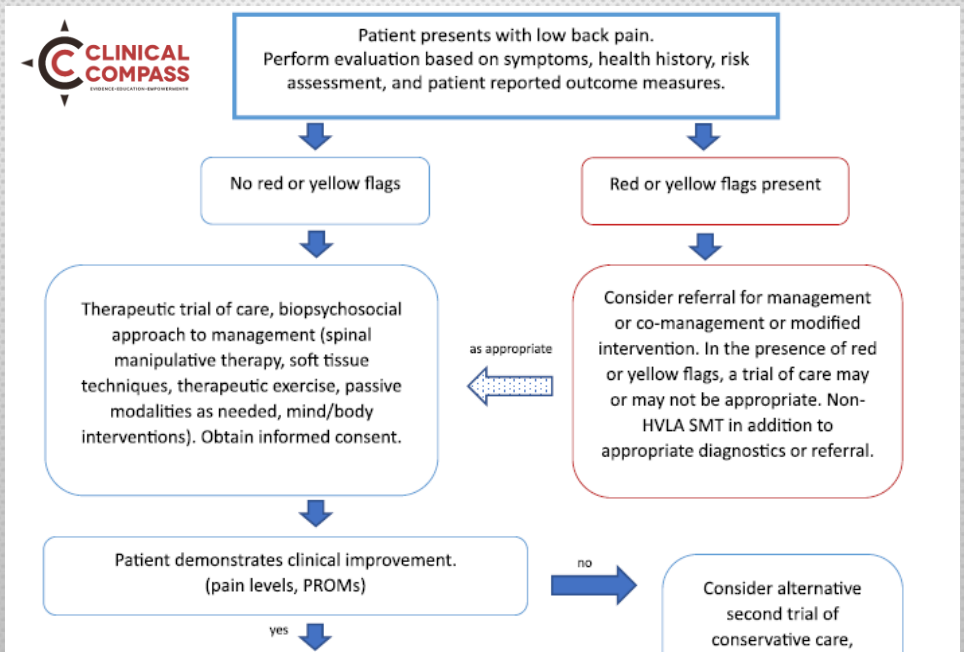
Best-Practice Recommendations for Chiropractic Management of Adult Patients With Mechanical Low Back Pain: A Clinical Practice Guideline for Chiropractors in the United States
J Manipulative Physiol Ther. 2022; Whalen et al.



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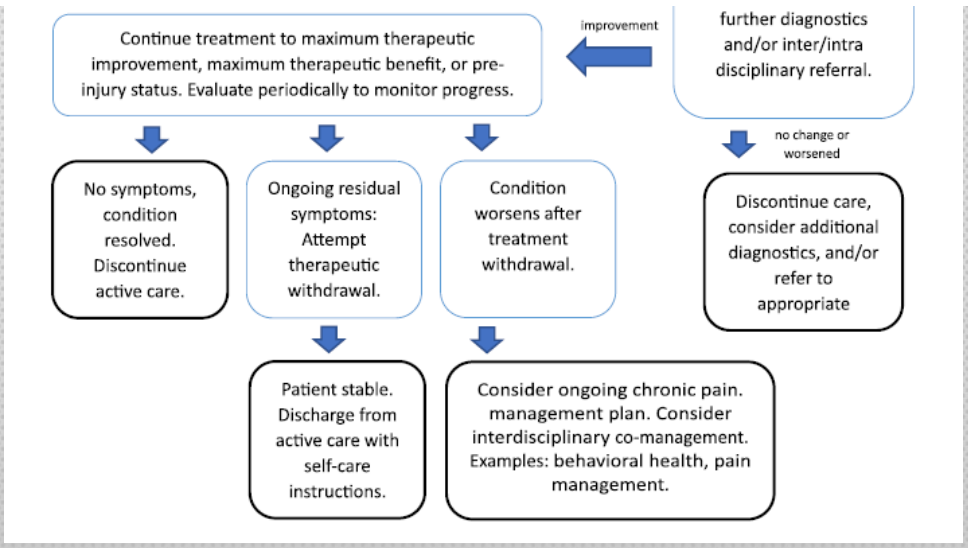

96

Table 5. *Visit Frequency and Duration of Care for Chiropractic Management of Acute, Subacute, and Chronic/Persistent Low Back Pain (Quality C, SoR 1)*

Type of Episode	Number of Treatment Visits	Duration of Care	Re-evaluation Period[a]
Acute and subacute	2-3/wk	2-4 wk	2-4 wk (per trial)
Mild exacerbation	1-6/episode	Per episode	Beginning and end of episode
Moderate or severe exacerbation	2-3/wk	2-4 wk	Every 2-4 wk
Chronic/persistent pain: scheduled interval of ongoing management for secondary and tertiary prevention[13,39]	1/mo[39,40]; up to 4/mo, with appropriate documentation[b]	Ongoing	Minimum of every 6 visits, or as needed to document changes[c]

97

98

Long Term Goals

1. Name an activity (such as walking or standing)
2. Give it a numeric value (distance or time)
3. Set a time limit (4 weeks or 2 months)
4. Keep them patient-centered

Pro tip: Use Outcome Assessment Tools (OATs)

99

THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

SECTION 1 - Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D **The pain is moderate and does not vary much.**
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 6 - Standing

A I can stand as long as I want without pain.
B I have some pain on standing but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D **I cannot stand for longer than 1/2 hour without increasing pain.**
E I cannot stand for longer than 10 minutes without increasing pain.
F I avoid standing because it increases the pain immediately.

The questionnaire that the patient completes during the re-exam now looks like this:

THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

SECTION 1 - Pain Intensity

A **The pain comes and goes and is very mild.**
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
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E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

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D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than 10 minutes without increasing pain.
F I avoid standing because it increases the pain immediately.

100

OATS Goals

- 10% improvement = minimum detectable change
- 30% improvement = meaningful change
- 50% improvement = substantial change

"Improve Oswestry score by 30% within four weeks"

101

Sample Oats-inspired Functional Goals

Enable patient to walk more than 100 yards without pain, within four weeks.

Enable patient to sit more than one hour without pain, within four weeks.

Enable patient to stand for more than one hour without pain, within four weeks.

Pro tip: This is how you know when the episode is over

102

Sample Oats-inspired Functional Goals

Enable patient to sleep more than six hours without being disturbed by pain, within four weeks.

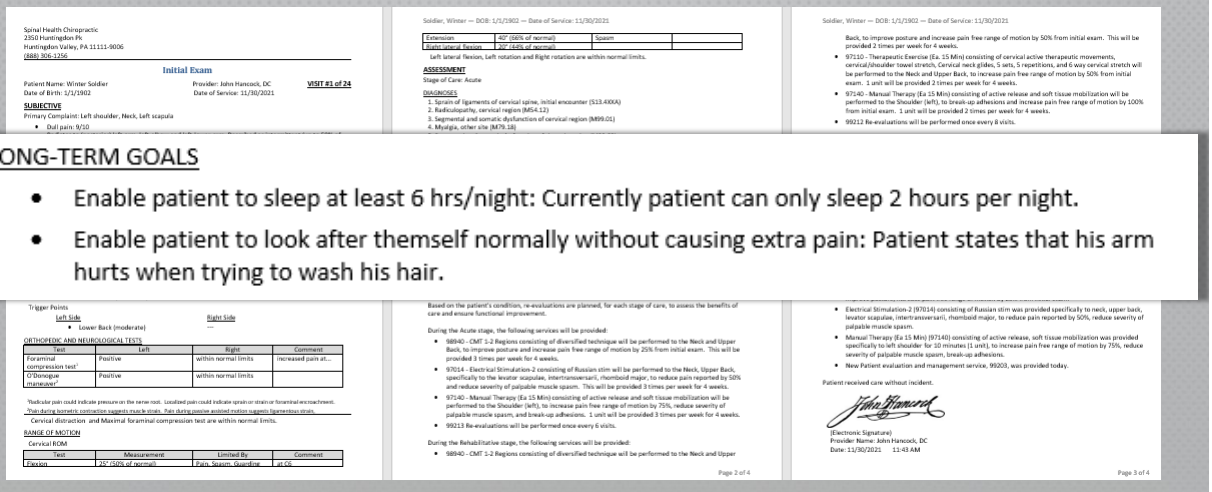
Enable patient to enjoy a social life without being disturbed by pain, within eight weeks.

Enable the patient to travel more than two hours, without being disturbed by pain, within eight weeks.

Pro tip: This is how you know when the episode is over

103

OATS Goals



Spinal Health Chiropractic
2350 Huntingdon Pk
Huntingdon Valley, PA 11111-9006
(888) 306-1256

Initial Exam

Patient Name: Winter Soldier — Provider: John Hancock, DC — VISIT #1 of 24
Date of Birth: 1/1/1902 — Date of Service: 11/30/2021

SUBJECTIVE
Primary Complaint: Left shoulder, Neck, Left scapula
- Dull pain: 9/10

Soldier, Winter — DOB: 1/1/1902 — Date of Service: 11/30/2021

Extension	40° (66% of normal)	Spasm	
Right lateral flexion	20° (44% of normal)		

Left lateral flexion, Left rotation and Right rotation are within normal limits.

ASSESSMENT
Stage of Care: Acute

DIAGNOSES
1. Sprain of ligaments of cervical spine, initial encounter (S13.4XXA)
2. Radiculopathy, cervical region (M54.12)
3. Segmental and somatic dysfunction of cervical region (M99.01)
4. Myalgia, other site (M79.18)

Soldier, Winter — DOB: 1/1/1902 — Date of Service: 11/30/2021

Back, to improve posture and increase pain free range of motion by 50% from initial exam. This will be provided 2 times per week for 4 weeks.
- 97110 - Therapeutic Exercise (Ea. 15 Min) consisting of cervical active therapeutic movements, cervical/shoulder towel stretch, Cervical neck glides, 5 sets, 5 repetitions, and 6 way cervical stretch will be performed to the Neck and Upper Back, to increase pain free range of motion by 50% from initial exam. 1 unit will be provided 2 times per week for 4 weeks.
- 97140 - Manual Therapy (Ea 15 Min) consisting of active release and soft tissue mobilization will be performed to the Shoulder (left), to break-up adhesions and increase pain free range of motion by 100% from initial exam. 1 unit will be provided 2 times per week for 4 weeks.
- 99212 Re-evaluations will be performed once every 8 visits.

LONG-TERM GOALS
- Enable patient to sleep at least 6 hrs/night: Currently patient can only sleep 2 hours per night.
- Enable patient to look after themself normally without causing extra pain: Patient states that his arm hurts when trying to wash his hair.

Trigger Points
Left Side — Right Side
- Lower Back (moderate)

ORTHOPEDIC AND NEUROLOGICAL TESTS

Test	Left	Right	Comment
Foraminal compression test*	Positive	within normal limits	increased pain at...
O'Donogue maneuver*	Positive	within normal limits	

*Radicular pain could indicate pressure on the nerve root. Localized pain could indicate sprain or strain or foraminal encroachment.
*Pain during isometric contraction suggests muscle strain. Pain during passive assisted motion suggests ligamentous strain.
Cervical distraction and Maximal foraminal compression test are within normal limits.

RANGE OF MOTION
Cervical ROM

Test	Measurement	Limited By	Comment
Flexion	25° (50% of normal)	Pain, Spasm, Guarding	at C6

Based on the patient's condition, re-evaluations are planned, for each stage of care, to assess the benefits of care and ensure functional improvement.

During the Acute stage, the following services will be provided:
- 98940 - CMT 1-2 Regions consisting of diversified technique will be performed to the Neck and Upper Back, to improve posture and increase pain free range of motion by 25% from initial exam. This will be provided 3 times per week for 4 weeks.
- 97014 - Electrical Stimulation-2 consisting of Russian stim will be performed to the Neck, Upper Back, specifically to the levator scapulae, intertransversarii, rhomboid major, to reduce pain reported by 50% and reduce severity of palpable muscle spasm. This will be provided 3 times per week for 4 weeks.
- 97140 - Manual Therapy (Ea 15 Min) consisting of active release and soft tissue mobilization will be performed to the Shoulder (left), to increase pain free range of motion by 75%, reduce severity of palpable muscle spasm, and break-up adhesions. 1 unit will be provided 3 times per week for 4 weeks.
- 99213 Re-evaluations will be performed once every 6 visits.

During the Rehabilitative stage, the following services will be provided:
- 98940 - CMT 1-2 Regions consisting of diversified technique will be performed to the Neck and Upper

Page 2 of 4

- Electrical Stimulation-2 (97014) consisting of Russian stim was provided specifically to neck, upper back, levator scapulae, interstransversarii, rhomboid major, to reduce pain reported by 50%, reduce severity of palpable muscle spasm.
- Manual Therapy (Ea 15 Min) (97140) consisting of active release, soft tissue mobilization was provided specifically to left shoulder for 10 minutes (1 unit), to increase pain free range of motion by 75%, reduce severity of palpable muscle spasm, break-up adhesions.
- New Patient evaluation and management service, 99203, was provided today.

Patient received care without incident.

(Electronic Signature)
Provider Name: John Hancock, DC
Date: 11/30/2021 11:43 AM

Page 3 of 4

104

Short-term Goals

During the Rehabilitative stage, the following services will be provided:

- 97110 - Therapeutic Exercise (Ea. 15 Min) consisting of cervical active therapeutic movements, cervical/shoulder towel stretch, Cervical neck glides, 5 sets, 5 repetitions, and 6 way cervical stretch will be performed to the Neck and Upper Back, to increase pain free range of motion by 50% from initial exam. 1 unit will be provided 2 times per week for 4 weeks.

During the Strengthening stage, the following services will be provided:

- 97110 - Therapeutic Exercise (Ea. 15 Min) consisting of cervical active therapeutic movements, Cervical rotator exercise with resistance, 5 sets, 5 repetitions, and Cervical neck glides will be performed to the Neck and Upper Back, to increase pain free range of motion by 100% from initial exam and enable patient to manage injury without re-aggravation. 2 units will be provided 1 time per week for 4 weeks.

105

Short Term Goals:
The following are the short term goals I have outlined for [redacted]s treatment plan; reduce pain, increase pain-free range of motion, restore normal vertebral segmental motion and increase ability to move the affected area

Short term goals restated:

1. Reduce pain
2. Increase pain-free ROM
3. Restore normal vertebral segmental motion
4. Increase ability to move affected area

Short term goals improved:

1. Reduce VNRS from 8/10 to 5/10 within 2 weeks
2. Increase pain-free ROM by 50% within 2 weeks
3. If you restore normal vertebral segmental motion, you can't adjust anymore, right?
4. How is this different than number 2?

106

Two weeks later:

Assessment:
PROGRESS AND GOALS:
Progress for [redacted] has been slow but constant. The present course of treatment should continue for another 2 weeks, at which time another re-evaluation will be done regarding his condition and the future course of treatment.

Assessment should discuss progress towards goals

- Were goals achieved?
- If not, why?
  - Patient went on vacation
  - Patient fell down the stairs
- How will the care plan change to adapt to goals that were not met?
  - Easier or harder exercises?
  - More or fewer visits?
  - Referral or new diagnostic test?

107

Two weeks later:

Short Term Goals:
My short term goals for [redacted] are; reduce pain by 10% by h[redacted]next re-evaluation, increase strength, increase endurance, increase ability to move the affected area and increase ability to exert force to affected area.

Short term goals restated:

1. Reduce pain by 10%
2. Increase strength *(Is there documented loss of strength?)*
3. Increase endurance *(How do you measure this?)*
4. Increase ability to move affected area *(Measurable?)*
5. Increase ability to exert force to affected area

108

20 visits, 40 pages, this is the closest thing to goals

F

Treatment to be provided:
Procedures
Therapeutic Exercises (Strength, Endurance, Stability), Massage

Modalities
To Improve (Pain Relief, Decrease Inflammation, Increase Blood Flow, Improve Tissue Healing)

2/3/23 visit 1

Short Term Goals:
1: (4 Weeks) | Reduce pain levels by 50%
2: (4 Weeks) | Increase strength deficits from 4-/5 to 4/5
3: (4 Weeks) | Improve ROM deficits by 50%
Long Term Goals:
1: (12 Weeks) | Reduce pain to 0/10
2: (12 Weeks) | Increase strength to 5/5
3: (12 Weeks) | Improve ROM to WFL in all planes

D

3/5/23 visit 10

Short Term Goals:
1: (4 Weeks) | Reduce pain levels by 50% |
2: (4 Weeks) | Increase strength deficits from 4-/5 to 4/5 |
3: (4 Weeks) | Improve ROM deficits by 50% |
Long Term Goals:
1: (12 Weeks) | Reduce pain to 0/10 |
2: (12 Weeks) | Increase strength to 5/5 |
3: (12 Weeks) | Improve ROM to WFL in all planes |

109

D+

PATIENT GOALS: Pt wishes to eliminate pain and tension, restore normal strength and mobility, return to PLOF.

C

4 Week Goals: reduce short leg by 50%, reduce pain to (3-4) pain, increase A/PROM in affected areas by 10-15%, increase muscle strength by 1/2 manual muscle grade in the weakened areas, improve postural awareness and neuromuscular function in muscle groups.

B-

GOALS: Short Term Goal: Decrease and Centralize pain to less than 3/ 10 while at rest. **4 weeks** Increase A/PROM by 10-15%. **4 weeks** Increase their strength by 1/2 manual muscle grade in the weakened areas. **4 weeks** Improve postural awareness and NMF in muscle groups. **4 weeks** Independent with HEP and start to improve function. **4 weeks** Long Term Goal: Decrease and Centralize pain to 0-2/10 levels during activity and ADL's **8 weeks** Increase A/PROM to within functional/normal ranges. **8 weeks** Increase their strength to 5/5 manual muscle grade in the weakened areas. **8 weeks** Resume proper postural control and proprioception in muscle groups. **8 weeks** Return to PLOF without restrictions. **8 weeks**

110

A

Treatment Plan and Goals

Based on the Neck Disability Index Assessment questionnaire he completed on 5/13/2019 our plans are to treat Mr. Back for 9 visits in an attempt to reduce his neck pain which is affecting his ability to perform typical daily functions (ie: personal care, walking and sitting). Those daily functional deficits are summarized as follows: Pain Intensity - he describes as mild. Headaches - he describes as slight and infrequent. Work - he is able to do his usual work, but no more. Driving - he can drive as long as he wants with slight neck pain. He will be re-evaluated on/by 6/14/2019 to reassess his progress.

Based on the Revised Oswestry Assessment questionnaire he completed on 5/13/2019 our plans are to treat Mr. Back for 9 visits in an attempt to reduce the scoring deficits he is experiencing as summarized: Sleep well without pain. Travel anywhere without pain. He will be re-evaluated on/by 5/14/2019 to reassess his progress.

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Treatment Goals

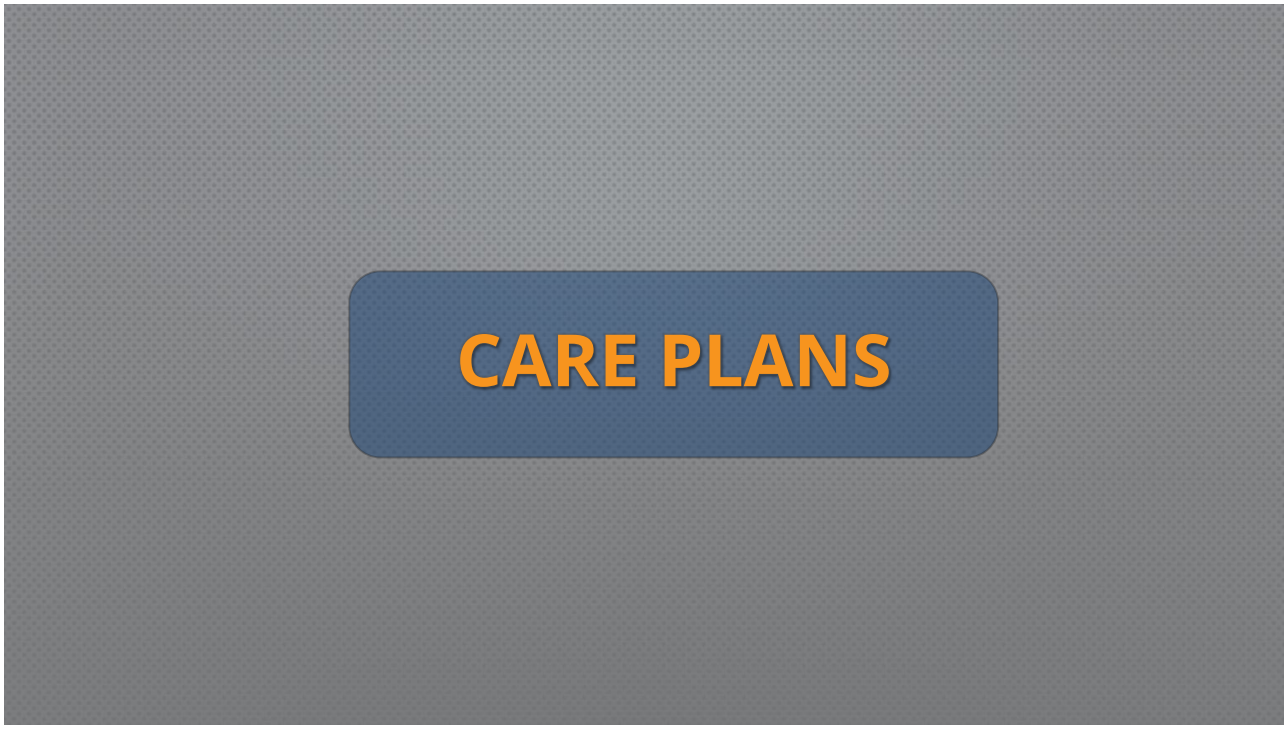
- Based on the Revised Oswestry Assessment questionnaire she completed on 1/29/2020 our plans are to treat Ms. Crabtree for 12 visits in an attempt to reduce the scoring deficits she is experiencing as summarized: Reduce pain when lifting heavy weights placed in a conveniently positioned place like a table. Sit in any chair for any length of time. Stand for more than 1 hour without pain. Sleep well without pain for a full night. Participate in a normal social life without pain. Travel anywhere without pain. Reduce her pain which she describes as fluctuating. She will be re-evaluated on/by 2/28/2020 to reassess her progress.
- Decrease left lower back and sacroiliac pain to a 0/10 VAS in four weeks.
- Improve strength and endurance of the lumbar core, piriformis, glute maximus, left glute medius, latissimus dorsi and lower trapezius in four weeks to a +5/5.
- Prepare the patient for a home-based exercise program.

111

Take Away

- Learn the essential pieces of a care plan
- Use evidence-based guidelines
- Create goals that establish medical necessity

112



113

114

Take Away

- Discover who gets picked on
- Use the chain of medical necessity
- Create rock solid care plans
- Identify what payers are looking for

115

NAILING MEDICAL NECESSITY AND AVOIDING AUDITS

Presented by Evan M. Gwilliam, DC MBA
CPC CCPC QMCC CPMA CPCO AAPC Fellow

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Evan.Gwilliam@Practisync.com

116


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Evan.Gwilliam@Practisync.com

117