PRESENTS A 3 CREDIT COURSE
EMCOMPASSING:

THE ETHICS OF EVIDENCE-BASED
DOCUMENTATION, RECORDKEEPING,
CODING AND FRAUD AND ABUSE ISSUES

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THE ETHICS OF DOCUMENTATION,
RECORDKEEPING, CODING AND FRAUD
AND ABUSE ISSUES

According to Webster’s New World Dictionary, ethics is defined as “a
system of moral standards or values.”). In Dorland’s Illustrated Medical Dictionary, ethics is defined as “the rules or principles which govern right conduct.” The dictionary goes on to define clinical ethics as “the application of ethical analysis to decision making in the care of individual patients and defines medical ethics as “the values and guidelines that should govern decisions in medicine.”

Generally, there is no such thing as: CHIROPRACTIC ETHICS, MEDICAL ETHICS OR BUSINESS ETHICS. What does exist is Professional Ethics. This may be defined as the study of moral choices that conform to professional standards of conduct. In many instances, professional ethics are defined in state statute and rules. The legislative bodies along with the respective regulatory boards set minimal professional standards, ethics and boundaries.

When working with patients the following questions should be asked of oneself:

1. Am I making unfounded claims regarding expected results of treatment?
2. Am I setting myself above my peers or other professionals?
3. Am I being careful when communicating with the public that chiropractic is a better form of treatment than the medical treatment they are presently receiving?
4. Am I basing my diagnosis on clinical judgment ONLY?
5. Am I diagnosing to benefit litigation?
6. Am I being influenced by third parties to diagnose for increased remuneration or time of treatment?
7. Am I being influenced by third parties to curtail treatment or services based remuneration or treatment time?
8. Am I treating the patient, the patient’s wallet or the patient’s policy?
9. Am I establishing medical necessity for the treatment or tests that are being rendered?
10. Am I correlating by billing with the appropriate documentation?
11. Am I documenting all services including history, examination, medical decision making, tests, procedures, etc.?
12. Am I coding to report what is medically necessary, or am I coding for higher reimbursement?
The physician should remember that they are the ultimate decision maker relating to the care of the patient. They are the ones who will be held responsible for their behavior. It is unwise to assume that the word of an attorney, CPA, or practice management consultant can authorize you make clinical decisions which result in compromises of ethical behavior. You have a license to loose, not them!

With these ethical factors in mind, how would one define “STANDARD OF CARE”?

A legal definition of Standard of Care is, “the watchfulness, attention, caution and prudence that a reasonable person in the circumstances would exercise… Failure to meet the standard is negligence, and any damages resulting there from may be claimed in a lawsuit by the injured party.”

Another definition would be “A diagnostic and treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstances… The level at which the average, prudent provider in a given community would practice. It is how similarly qualified practitioners would have managed the patient’s care under the same or similar circumstances.”

Most states have their own definition of Standard of Care. The following is an example from the State of Florida:

“The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light or all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers”. The law goes on to say “The provisions of this subsection shall apply only when the medical intervention was undertaken with the informed consent of the patient…” It further states “The legislature is cognizant of the changing trends and techniques for the delivery of health care in this state and the discretion that is inherent in the diagnosis, care, and treatment of patients by different health care providers.”

INFORMED CONSENT

With the thoughts of Professional Ethics, Moral Choices and Physician Constraints in mind, prior to treating any patient, the physician MUST obtain the patient’s permission to examine, test, or treat that individual. The patient has the right to participate in decisions involving his/her health care.
The patient should not be subjected to any procedure without his/her voluntary, competent, and understanding consent. The patient always has the right to accept or reject treatment. The physician should, when changing or altering treatment or testing parameters, obtain additional informed consent. Each practitioner should become familiar with their state laws concerning written, oral, or implied informed consent.

In general, informed consent, whether written, oral, or implied should contain, at a minimum the following:

- Material risks inherent in the treatment
- Probability of those risks
- Availability and nature of other treatment options
- Risks inherent in other treatment options and probability of those risks
- Nature of procedure
- Risks and dangers of not receiving treatment

Further, according to the Center for Medicare and Medicaid Services the following informed consent guidelines should include:

- “Description of the procedure or surgery, including anesthesia.
- Why the procedure is recommended.
- Risks and benefits to the patient and degree of severity or likelihood of complications.
- Treatment alternatives, including related risks and benefits.
- Probable consequences of declining recommended or alternative therapies.
- Name of doctor or surgeon conducting procedure and administering anesthesia.
- Other physicians, including residents, performing tasks related to the procedure.”

The reality is that most patients sign the office forms without reading them, or they read them and don’t understand them. It is most important, especially with an informed consent form, that the patient understand what they are signing. The Centers for Medicare and Medicaid Services (CMS) are calling for hospitals and physicians to design their forms so that they are patient friendly. They should include treatment alternatives and the risks of no treatment, as stated above. You might want to include a statement that
reflects that the patient understands what they have read.

Over the years, I have been involved in hundreds of depositions and court cases. In almost every one of them, the following question is asked:

“Do you have an informed consent signed by the patient?”

In many cases, the failure to have, in the medical records, a copy of the informed consent gives an attorney an opening for a malpractice suit or a complaint to be made before a state regulatory board.

According to the Association of Chiropractic Colleges, “prior to performing diagnostic testing and prior to implementing chiropractic procedures, the patient should be informed about the material and inherent risks and common options to the recommended care and the associated risks, including the risk of refusing care. If the patient wishes to continue he/she should give his/her consent. The Doctor should have a record in her/her clinical file documentation which confirms that consent was given by the patient to the diagnostic testing and/or the chiropractic procedure.”

Again, from the Association of Chiropractic Colleges, “The Doctor should obtain informed consent from patients before carrying out any diagnostic or therapeutic procedure on patients.”

**COMMON VIOLATIONS OF ETHICAL BEHAVIOR IN CLINICAL PRACTICE**

*Coding, Time and Documentation*

The physician makes inappropriate ethical decisions which lead to actions that eventually result in fraud and abuse. Basically, the physician is able to get away with little things which may generate a few extra dollars, in the short term. This type of thought and action leads to upcoding, bundling, and unbundling which carry with it the probability of problems with regulatory boards and even criminal charges.

*Treating the policy instead of the patient*

The physician customizes a treatment plan which is designed to maximize reimbursement from either the patient or the third party payer.

*Billing for services not performed or not medically necessary*

When the physician treats “ghosts” (patients who are reportedly
receiving treatment but are not seen) and reports services never received (padding), that activity is an act of fraud. If a service is provided that is not based on medical necessity and documented, it is considered unethical and may be a fraudulent activity.

**Overutilization**

Providing services which are designed to increase remuneration and are not based on medical necessity.

**Tests and/or Procedures**

The ordering of tests or procedures which are not based on the needs of the patient (medical necessity), and for which the referring source receives some form of remuneration. This type of activity is considered a “kickback”. This is not only unethical, but also fraud.

**OVERVIEW**

“The term “ethical” is used in opinions of the Council on Ethical and Judicial Affairs to refer to matters involving (1) moral principles or practices and (2) matters of social policy involving issues of morality in the practice of Medicine. The term “unethical” is use to refer to professional conduct which fails to conform to these moral standards or policies.” Once again, I am using the term medical in its generic sense.

“While physicians should be conscious of costs and not provide or prescribe unnecessary medical services, concern for the quality of care the patient receives should be the physician’s first consideration.”

**ETHICS AND THE LAW**

“The term “medical ethics” may be regarded as an inaccurate designation. It might be more appropriately termed “the application of ethical theory and moral practice to medicine.” Basically medicine operates in a certain ethical climate. It is essential that ethical principles be applied to the physician-patient interaction. Ethics may be defined as the philosophic inquiry into the nature and grounds of morality. Morality is the general name for moral judgments, standards, and rules of conduct. These include not only actual but also ideal judgments, standards, and rules. The major goal of ethics is to give rational grounds for these judgements.”
It is the responsibility of any healthcare provider to administer ONLY those services the patient requires to achieve maximum therapeutic benefit for the diagnosed condition.

Basically there are 9 compromises of ethical behavior. They are:

1. Kickbacks
2. Waiver of co-payments
3. Overcharging
4. Unnecessary tests or procedures
5. Sexual misconduct
6. Paid referrals
7. Mis-coding
8. False reporting

Kickbacks, are defined as “a commercial bribe paid by a seller to a purchasing agent in order to induce the agent to enter into the transaction.”

Waiver of co-payments is generally defined as a non required payment, of a contracted co-payment, for services rendered by the healthcare provider.

Unnecessary tests or procedures are not only violations of ethical behavior, but, by not establishing the medical necessity for the tests or procedures, in most cases, are violations of statutes and rules.

Sexual misconduct is not only a physical act. It may be considered sexual misconduct if something is said or inferred that is of a sexual nature.

In most states it is unlawful, as well as unethical, to pay someone to refer patients to the physician’s office.

Mis-coding, especially up-coding, is not only unethical, in most states is considered fraud.

False reporting is when the records do not reflect what actually happened. It is usually done to increase reimbursement or to cover up something that should or should not have occurred.

Samuel Johnson said “INTEGRITY WITHOUT KNOWLEDGE IS WEAK AND USELESS, AND, KNOWLEDGE WITHOUT INTEGRITY IS
DANGEROUS AND DREADFUL.” The reality is it is up to you to choose the ethical pathway.

According to the Office of the Inspector General, “Upcoding was also a significant problem resulting in $15 million in overpayment.” Other comments relating to chiropractic services in the Medicare program include the following:

1. 2/3 of all claims submitted to Medicare had errors.
2. 16% were miscoded and billed at the wrong level of service.
3. 8% were undocumented.
4. 12% had multiple errors.
5. $285 million in improper Chiropractic Medicare payments were made.

Dr. Fabrizio Mancini said “in protecting the health, safety and welfare of the public, you also protect the integrity of our profession.” A Japanese proverb states “the reputation of a thousand years may be determined by the conduct of one hour.” Ethics impacts on both.

The New York State Chiropractic Association, Chiropractic Code of Professional Ethics, states “professional ethics are based upon the fundamental principles of ethics and professional behavior imposed upon all Chiropractors.” The code of ethics goes on to say “the ethical foundations upon which these principles are based are those established moral obligations insuring the dignity and integrity of the profession. The object of this formal code is to clearly define the obligations and duties incumbent upon each and every Chiropractor.”

Some doctors stretch things gradually, with coding, time, and documentation and make inappropriate ethical decisions leading them down the path of fraud. They get away with the little things and make a few extra dollars without ever considering they will eventually get caught.

It is, therefore, important to fully understand and apply appropriate reporting and coding procedures. The ethics of appropriate documentation, recordkeeping, and coding cannot be overemphasized.

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EVIDENCE BASED CHIROPRACTIC

What is it, and why in the world do I need to know it? This is a question that is both troubling and soothing at the same time. Basically, it is a systematic manner in which to identify and report the validity of what you do. It allows for the replacing of inappropriate and inaccurate treatment parameters with new ones, based on “scientific” and proven evidence. Since chiropractic is a philosophy, science and an art, it should not be bogged down by strictly a belief system, i.e. “I believe it works, therefore, it works” or “B.J. said it, therefore, it is.”

The use of evidence based chiropractic is not intended to minimize the importance of anecdotal records, personal expertise or documented evidence. However, these forms of documentary evidence should be recognized for what they are, a part of the evidence which is necessary to justify what chiropractic does and how it does it. It is an important part of the research which is necessary to lend credibility to the chiropractic profession. As a profession, chiropractic cannot say that what we do works without having acceptable evidence to justify that it works. If we, as a profession, are to participate in main stream health care, then we must hold our bar of credibility up to the standards of all health care professions. Nothing more and nothing less!

Generally speaking, the third party payer system has one, and only one responsibility. That responsibility is to collect premiums and pay out, only, for those services that are “reasonable, customary, and medically necessary”. It seems that they want, at their discretion, to determine what is reasonable, necessary, and customary. Sometimes their decisions are arbitrary at best, however, according to some sources; they are using accepted research parameters to make those determinations. In addition, it appears that at this point in history, the health care system, regulatory boards and government agencies use the same or similar parameters. Anecdotal and experiential notations are, by themselves, not acceptable. According to medical (used in its generic sense) educators at McMaster’s University it seems it is important to “educate physicians about the importance of integrating research evidence into their clinical practices, and also how to integrate new found knowledge with their expertise as clinicians and the desires and preferences of the patients they cared for.”1
Some would say that evidence based chiropractic is a deviation from traditional chiropractic. That could not be further from the truth. If D.D. Palmer and B.J. Palmer had not experimented, researched, and explained their theories, where would chiropractic be today? Evidence based chiropractic, like evidence based medicine, is not a “cookbook” approach to health. It is the opposite! It is “a continuing process of integrating the best evidence (that which is the most current and as strong as possible) with the past training and expertise of the clinician…” According to J. Bolton, the definition of evidence based practice is “clinical decision-making based on (1) sound external research evidence combined with individual clinical expertise and (2) the needs of the individual patient.”

According to M. Haneline, a good definition of evidence based chiropractic would be “actively seeking support for and improvement of chiropractic clinical practices through the integration of the best available research evidence, combined with clinical expertise and patient values.” It should be noted, at this point, that EBC (evidence based chiropractic) is unique and somewhat different than traditional EBM (evidence based medicine). It would appear that in EBM, because of the nature of its method of practice (i.e. drugs, surgery, nutritionals, etc.) it would be easier to perform studies which are both double blind and have a placebo effect. In chiropractic, it becomes more difficult to evaluate the results of spinal manipulation because the clinician, and sometimes the patient, will know whether or not the adjustment was real or just a placebo.

Because of some of the incongruities in the nature and manner of the research when comparing EBM and EBC, some outside the chiropractic profession may conclude that the EBC studies are flawed. This is not the case. The reality seems to indicate that EBC research, when performed under the strictest parameters available, is an acceptable form of research although not necessarily the same as EBM. The final conclusions is, has, and always will be, what is in the best interest of the patient. When we get bogged down with philosophy superseding science and art, we are treading on some very thin ice. All three must be considered and evaluated based on the needs of the patient. Blind obedience is a form of pseudo-science or a radical religion, not a part of chiropractic.

With all of this in mind, how should we apply evidence based chiropractic in our offices? According to Haneline, the following are the steps necessary in


1. Ask a clinically relevant question.
2. Search the literature to find the best available evidence to answer your question.
3. Appraise the evidence for validity and applicability to the clinical circumstances.
4. Apply the relevant evidence to the clinical situation
5. Evaluate your effectiveness in carrying out steps 1 through 4 and revise if necessary.

The Association of Chiropractic Colleges state, “The foundation of chiropractic includes philosophy, science, art, knowledge and clinical experience.” As previously mentioned, chiropractic philosophy is a part of EBC, however, philosophy is not the end all, and be all, of chiropractic. As new research becomes available, it is our responsibility, as health care providers, to adapt, analyze, and incorporate new information into our collective psyche. The constant repetition, with blind obedience, that all that was known in 1895 is all that will ever be known about chiropractic, is pure folly. Chiropractic is a living, evolving form of health care. I believe that the founding fathers of chiropractic would turn over in their graves if they thought that this profession was stuck in the past. Evidence based chiropractic is the future, and I believe that our forefathers would have embraced, endorsed and participated in this type of practice.

It might, at this point, be interesting to note that chiropractic is not the only form of healthcare that encounters some difficulty in gathering purely “objective” evidence based research. In the book, “Physical Rehabilitation, Evidence-Based Examination, Evaluation, and Intervention”, it states “Applying EBP to rehabilitation is particularly challenging because trials evaluating rehabilitation interventions cannot always meet the methodological standards applied to other types of clinical trials. In particular, subjects, providers and evaluators frequently cannot be blinded to the application of a rehabilitation intervention because many interventions used in rehabilitation, such as manual therapy techniques, depend on the skill of the person applying them and thus necessitate at least nonbinding of the person providing the treatment. Other rehabilitation interventions, such as exercise, depend on the cooperation of the subject and thus cannot be applied without subject awareness... Many rehabilitation interventions also cannot be standardized because they vary with the skill, training, and
experience of the provider.”

“In clinical practice, documentation essentially consists of recording the subjective complaints of patients, the objective findings, one’s assessment, and the plan for case management.” Good clinical documentation should be a reflection of the thought processes involved in patient management and provide evidence of the patient’s progress…” Generally, doctors should use the best available research data and information to support the nature and course of the care that they provide for their patient. Outcome evaluations should be used to document the changes in the patient’s condition. In order to determine which outcome evaluations should be used, the physician should familiarize themselves with any number of formats. A good source to learn about outcome formats is the book “Evidence-Based Chiropractic Practice”, by M. Haneline, chapter 10.

REFERENCES
DOCUMENTATION

*IF YOU DON’T WRITE IT DOWN, IT DID NOT HAPPEN!*  
*ANSWER THE QUESTIONS BEFORE THEY ARE ASKED!*  
*TELL A STORY!*  
*PAINT A WORD PICTURE!*

**DOCUMENTATION AND RECORD/KEEPING HAVE ABSOLUTELY NOTHING TO DO WITH THE METHOD OF PAYMENT!!**

In today’s litigious society, it becomes more and more important for physicians to document their course of care. Establishing the medical necessity for care is the foundation of documentation.

In order to control skyrocketing costs in medical care, i.e. tests, surgeries, medications, therapeutic procedures, etc., the government, third party payers and regulatory boards have legislated reforms, formulated policies, and issued rules in an attempt to contain those costs. In doing so, they have increased *utilization reviews* and placed *medical management* under the microscope.

It is not the purpose or the place of this author to pass judgment on whether or not these reviews are justified or not. It is my intention to bring these facts to you and provide information which will permit the physician to meet the requirements of today’s real world. It is also my goal to help keep you, the practicing physician, away from Regulatory Boards, and in some instances, the Judicial system.

In order to meet new, and sometimes restrictive requirements of documentation and recordkeeping, the physician should consider utilizing *EVIDENCE-BASED (discussed in this workbook)* reporting procedures when possible.

It is important to remember that medical records are private and should be held in a secure location. One person, usually the doctor or the office manager, should be appointed as *MEDICAL RECORDS CUSTODIAN*. 
The purpose of documentation and accurate recordkeeping is to have information available relating to the care of the patient and the medical necessity required to support your treatment plan, testing, or procedures. It also enables other health care providers, who may see the patient in the primary provider’s absence or for co-management purposes, to follow the rationale for the current treatment plan. The information contained in the medical records confirms and establishes the patient’s need for treatment, testing, and procedures. It also records all treatment outcomes.

The medical records (documentation and recordkeeping) are the first line of defense in a medical malpractice suit. Without appropriate medical records, there is no defense and you, the treating physician, may be personally held liable.

**WHEN PROVIDING PROFESSIONAL SERVICES,**

**THE CARDINAL RULE IS:**

- NO HISTORY LEVEL SHOULD BE DETERMINED,
- NO EXAMINATION SHOULD BE PERFORMED,
- NO TEST SHOULD BE ORDERED, AND
- NO TREATMENT SHOULD BE RENDERED,

UNTIL THE MEDICAL NECESSITY FOR THAT SERVICE HAS BEEN ESTABLISHED,

IN WRITING.

It should always be remembered that the medical/chiropractic records are legal documents and may be subpoenaed to court!

Although, in most states, there are no specific statutes or rules relating to the manner in which records should be kept (hand written, computer generated, typed, dictated, etc.), there are ground rules which should be followed in order to establish the medical necessity and appropriateness of care.

When reviewing your documentation, the following should be considered:

1. Does the history, as provided by the prospective patient,
provide information which would justify an examination?
2. Is the examination performed based on the information obtained in the history?
3. Has information been provided which identifies the decision making choices made by the physician?
4. Does the history, examination and decision making data provide enough information to justify tests or procedures?
5. Does the documentation support the diagnosis?
6. Are all treatment procedures supported by the history, examination, medical decision making, diagnostic tests, and clinical judgment?
7. Are there research, data, and clinical support for your opinions (evidence-based practice)?

REMEMBER, ANSWER THE QUESTIONS BEFORE THEY ARE ASKED!

ESTABLISHING AN APPROPRIATE DOCUMENTATION/RECORDKEEPING SYSTEM

Before establishing a Documentation/Recordkeeping system for the office, it is necessary to know where problems begin and how to avoid them. With this in mind, let’s look at some of the common mistakes relating to Documentation and Record keeping:

1. The medical chart is chaotic
2. Illegible records
3. Patient’s name is not on each entry or at the top of the page
4. Doctor’s name is not on each entry or at the top of the page
5. The date of service is not noted
6. The subjective portion of the notes are not credited to the person providing the information
7. In the objective portion of the notes, only the positive findings are recorded
8. Multiple formats for Documentation/Recordkeeping (P.I.,
Medical necessity is not established or recorded
10. A key to abbreviations and/or codes are not provided and easily accessible
11. Test results are not recorded
12. All comments into the record are exactly alike and/or generic in nature

These are just of few of the problems encountered. Let’s take stock of your office today: Take this self test and see where you stand.

1. Are your records legible? Yes No
2. Are your records dated? Yes No
3. Is the person providing services identified? Yes No
4. Are you erasing? Yes No
5. Do you initial outside reports when received? Yes No
6. Are you recording the information in the file? Yes No
7. Do you have informed consent? Yes No
8. Have you established medical necessity? Yes No
9. Do you take an appropriate history? Yes No
10. Do you perform an appropriate examination? Yes No
11. Do you record and describe all positive findings? Yes No
12. Do you record all negative findings? Yes No
13. Do you leave blank spaces on forms? Yes No
14. Do you order appropriate tests? Yes No
15. Are you performing follow-up examinations? Yes No
16. Are you using abbreviations or symbols? Yes No
17. Are you providing a key? Yes No
18. Is the name of the patient identified? Yes No
19. Is the medical chart organized? Yes No
20. Are you using “outcome assessments”? Yes No
21. Are you setting treatment goals? Yes No
22. Are you preparing a treatment plan? Yes No
23. Are you using 5 digit ICD-9 codes? Yes No
24. Are you using diagnosis pointing Yes No
25. Are you daily notes in a SOAP format? Yes No
26. Have you recorded clinical correlation? Yes No

To ensure proper Documentation/Recordkeeping, let’s take a look at the MEDICAL CHART.
THE PATIENT’S MEDICAL CHART

1. Patient information forms (usually filled out by the patient or their legal representative). If filled out by the legal representative, the name and relationship should be identified and recorded. If filled out by a translator, the name of that person should be identified.

2. If the patient has insurance, an Assignment of Benefits form, and copy of both sides of all insurance cards

3. If the patient is private pay, who is the responsible party?

4. If the patient has an attorney, the name, address, and phone number of the attorney

5. Release of information form (no information relating to the patient should be released without an authorization signed by the patient or the legal representative)

6. Informed Consent

   What is informed consent?

   It is a legal responsibility to make sure that each and every patient has sufficient knowledge relating to the care being provided to and for them. The physician who provides care to patients has the duty to encourage patients to participate in health care choices.

   Informed consent may be verbal or written (it is our recommendation to obtain written informed consent), but, certain information must be discussed and recorded.

   1. Risks and benefits of care.
   2. Rationale of care that is being recommended.
   3. A statement that the patient understands all explanations.
   4. Alternatives to care
   5. A statement from the patient authorizing the specific plan of care.  

   *NOTE*: When treatment is altered or changed, the informed consent should be updated. If special procedures (photography, special examinations, etc.) are contemplated, a separate
informed consent should be obtained.

7. Medical history
   A. Patient history
   B. Symptom and/or wellness care
   C. Examination findings
   D. Diagnosis
   E. Prognosis
   F. Assessment
   G. Treatment plan

8. Tests ordered or performed (lab results, x-ray findings should be included, when known)

9. Communication with other health care providers or agencies

10. Treatment plan

11. Billing information

12. Any other information relating to the care of the patient

SAMPLE OF A FOUR (4) PAGE MEDICAL CHART
One of the primary reasons to document, in this area, is to demonstrate the effectiveness of the care being provided to your patient. It is incumbent upon the physician or therapist (definition of therapist varies from state to state) to provide adequate documentation to the payer of the services and to monitor the progress of the patient. Without appropriate documentation, the third party payer may choose to terminate services and/or reject claims. It would be appropriate, at the beginning of care, to identify the activities of daily living that have been affected by the injury or illness. This would establish a baseline from which to measure patient’s improvement or lack of improvement.

Since documentation is usually the only form of communication between the third party payer and the provider of services, the manner in which that communication is carried out is vital. The provider of services should “paint a word picture” of what the problem is, what the treatment will consist of, and how the patient will benefit from the services recommended. The information should be submitted to the third party payer in a clear, concise, but comprehensive manner. All reports, papers or any forms of communication that are sent out of the office, should be of the highest quality and professional at all times. It is usually the only way a third party payer, an attorney, a regulatory board, etc., has of knowing you and your office. Once the third party payer can visualize the benefits of care, and the medical necessity of care, in most cases they will be able to understand the rationale for the recommended services. In other words, the provider has, when using this approach, given the third party payer a reason to pay the claim rather than reject it.

“Function”, defined as “the special, normal, or proper physiologic activity of an organ or part”, is a word which carries with it special meaning. It is a word whose meaning carries a great deal of weight in the world of rehabilitation, exercise, and activities of daily living. It is incumbent upon the provider of these types of services to demonstrate, in the records, that the care that is being administered to the patient results in functional improvement. In the real world, this means that it is not enough to say “that
someone’s range of motion has increased. So what? Just because someone can bend more at the elbow does not automatically mean that person can do more because of it.” Can the person now perform activities as a result of this improvement?  

Generally, the best way to document is at the time that the services are provided (contemporaneously). It is necessary to obtain informed consent (described later in this workbook) from the patient prior to providing services. Remember, the patient has the right to make the ultimate decision as to whether or not they wish to receive care. All documentation relating to the care of a patient must remain confidential. “Violating the confidentiality statutes of HIPPA, by disclosing information that should not be disclosed to another party, without permission, is punishable by fines of up to $50,000 or 1 year in prison (Liang, 2000).”

When discussing evidence based services, it may become necessary, when asked, for the provider to be able to document the rationale for their services. This may include, textbooks, journals and peer reviewed research. Remember, the medical necessity for care must be demonstrated. Without establishing why care is indicated and what the benefits of care are to the patient, the services may be considered not reasonable or necessary. It may also be determined, by a state regulatory board, that the services are over-utilization and/or exploitation of a patient.

Generally, physical therapy (procedures) should be functionally oriented and, therefore, address changes in function as compared to the patient’s condition prior to the reported injury or illness. When reporting therapeutic modalities or procedures, it is incumbent upon the provider to identify the location of the modality or procedure (in office, patient’s home, outside facility, etc.), and in the case of procedures, the amount of time spent with the patient (constant attendance). The general rule of thumb here is, the more specific the documentary notations, the better off you are.

When working with a patient, relating to activities of daily living, it is most important to identify, at the beginning of care, what impact the injuries or illness reported has had on specific activities. This will establish a baseline from which the provider may be able to determine levels of practical improvement.

The provider’s documentation is usually the only form of communication a
third party payer has of knowing whether or not the treatment that has been provided has had a positive effect on the patient. Most payers will make determinations on payment of services based on the progress of the patient. If no progress is demonstrated after a period of care, then, in many cases, they will terminate payment. 5

Whether discussing the medical necessity of physical therapy, rehabilitation, exercise, activities of daily living, etc., the documentation should be clear, precise, accurate and specific to the situation. The goals of treatment should be identifiable, realistic and achievable. In the documentation, progress toward the goals should be noted. The primary goal should always be to “optimize patient function at home, in the community, and at work”6

SUMMARY

The medical necessity for various forms of physical medicine (used in its generic sense) should be documented (see chapter on Physical Therapy) along with the physiologic effects of that therapy. The benefit of the therapy, to the patient, should also be noted.

THE DAILY NOTES

1. Notes should be complete and legible
2. The daily records should include:

   A. Subjective complaints: This is what the patient tells you about their problem (reason for the office visit), in their own words. This is not the place to editorialize
      1. Area of discomfort
      2. Side of involvement
      3. Visual analog scale
      4. Type of discomfort
      5. Radiation (intensity, duration, location, etc.)
      6. Paresthesias
      7. Altered ranges of motion
      8. Activities altered by complaints

   B. Objective findings: This is what the examiner finds during the evaluation
1. Intersegmental dysfunction
2. Tenderness (Mankopf’s sign): location, description
3. Hypertonicity (name of muscle, grade, side)
4. Inflammation (name of muscle, grade, side)
5. Spasm (name of muscle, grade, side)
6. Inspection and observation findings
7. Instrumentation findings
8. Testing (vitals, orthopedic, neurologic, x-rays, etc.)

C. Assessment: The thought process and conclusions
   1. Visit to visit conditional changes
   2. Subluxation levels and listings
   3. Functional increases and decreases
   4. Changes in diagnosis

D. Procedures/Plans: Components of care
   1. Adjustment
   2. Manipulation
   3. Soft tissue treatment
   4. Physical therapeutics
      a. modalities
      b. procedures
   5. Counseling
   6. Patient education

E. Periodic Reassessments: Based on medical necessity, and documented in the patient’s medical/chiropractic chart (record).
   1. To determine the nature and course of future care
   2. Determine the necessity of any diagnostic procedures
   3. Record any changes in the patient’s condition

F. Recommendations: Home care suggestions and instructions
   1. Day to day recommendations
   2. Home therapy
   3. Home exercises
   4. Work/lifestyles modifications (if qualified by training)
   5. Alterations of ADL’s (if qualified by training)
   6. Referrals
SYMBOLS

<  less than; before
>
|  leading to, producing
8  increased
88  much increased
9  decreased
99  much decreased

GRADE

+  positive, present
%  male
&  female
+/o  intermittent
?  questionable
Ψ  yields
♠  to
1  primary, first degree
2  secondary, second degree
3  Tertiary, third degree
O, ø  no change
B  bilateral
L  left
R  right
P  pain
T  tenderness

PAIN GRADING

1  mild
2  moderate
3  severe
4  very severe

PAIN FINDINGS

B  burning
D  dull
P  pain
Pn  pain
S  sharp

MUSCLE SPASM

0  no spasm
1  mild
2  moderate
3  severe
4  tonic spasm
5  clonus
REVIEW

Just think about the following:

The following is a brief list of the necessary steps for documentation:

- History (in the patient’s own words)
- Complaints (in the patient’s own words)
- Examination findings
- Diagnostic test results
- Medical Decision Making (how did you decide to do what you do)
- Plan of care
- Response to treatment (if the patient fails to respond to care, then why are you continuing to treat)

In a discussion relating to physical medicine and rehabilitation, it should be remembered that passive modalities are usually of short duration. That does not mean that each encounter is of short duration, but rather that the use of these modalities, in general, are of short duration. Remember the application of a modality is directed to the general complaints of the patient and, therefore, should be explained in the medical records. Most state laws require the justification of the use of a modality. Technique is not the justification for the use of a modality.

In the case of a personal injury or workers’ compensation accident, it is important to remember that treatment should be directed ONLY to the injury sustained as a result of the specific incident. While our philosophy states that we treat the entire patient, law requires us to limit the care that is being provided in these types of cases. Of course, the patient, if indicated, should be advised on the necessity of treatment after the acute care has been provided.

One of things that our profession has been accused of is lack of referrals. If a patient has not responded to the care that you are providing for them, perhaps a referral is indicated. Within our profession, we have a number of qualified specialists. For example, a chiropractic radiologist, chiropractic neurologist, or chiropractic orthopedist may be the person to whom you refer your patient. Their area of expertise, in conjunction with the fact that they are also doctors of chiropractic, may give you a very special perspective on
your patient. Why not use experts to assist in the care of your patient? Your referral not only shows your concern, it also shows your professionalism.

REFERENCES
5. Sames, Karen, “Documenting Occupational Therapy Practice, 2005
7. Grider, Deborah, “Medical Record Chart Analyzer, American Medical Association, 2002

GENERAL REFERENCES
FRAUD, ABUSE, AND COMPLIANCE

DEFINITIONS:

Fraud: Intentional deception to cause a person to give up property or some lawful right

Abuse: To use wrongly; misuse; to hurt by treating badly; wrong, bad or excessive use; mistreatment; injury; a bad, unjust, or corrupt custom or practice

NOTE: IN HEALTH CARE:

FRAUD MAY BE DEFINED AS AN UNLAWFUL ACTIVITY WHICH MAY RESULT IN AN UNAUTHORIZED BENEFIT OR PAYMENT.

ABUSE MAY BE DEFINED AS ACTIVITIES THAT MAY INJURE A PATIENT OR RESULT IN INAPPROPRIATE COSTS

EXAMPLES OF HEALTH CARE FRAUD AND ABUSE

1. Billing for services not rendered
2. Billing for unnecessary services (not establishing medical necessity)
3. Upcoding Performing one level of history, examination and/or medical decision making, but reporting a service above the level that is actually performed
4. Downcoding Performing one level of history, examination and/or medical decision making, but reporting a service below the level that is actually performed
5. Bundling A group of services that are usually reported separately, but are reported together

NOTE: This term is also used when an entity takes services which are usually reported separately and groups them together such as 98940 and 97140.

6. Unbundling Taking parts of a service that are usually reported together and reporting them as independent
7. Overutilization Providing services which are not based on medical necessity and are in excess of what is reasonable and necessary for the benefit of the patient
8. Kickbacks A monetary or “in kind” payment for a referral or service
9. Advertising See appropriate state statute and rule
10. Employee/independent contractor Legal advice should be obtained to meet regulatory requirements (STATE AND FEDERAL)

HOW TO AVOID FRAUD AND ABUSE PROBLEMS

1. Recognize and establish that only medically necessary services, that are within your scope of practice and consistent with regulatory requirements, are ordered or performed.
2. Ensure that there is proper documentation of all services rendered.
3. Submit for reimbursement only those claims that are in compliance with relevant laws, rules and guidelines.
4. Audit your claims and records. Make sure that your coding, billing and documentation are coordinated, medically necessary, and reasonable.
5. Appoint a medical records custodian.
6. Properly train and cross train all employees. Prepare an office manual identifying the training required of each employee. Have employees sign off on each area that they have received training.
7. Prepare a format in which complaints and corrective action steps are undertaken.
8. Have regularly scheduled meetings with the office staff to discuss problems, solutions, and procedures.

NOTE: DOWNCODING AND UNDERCODING APPEAR TO BE RATHER SIMPLE ANSWERS TO THE PROBLEM OF UPCODING. THIS, HOWEVER, IS NOT THE CASE! DOWNCODING AND UNDERCODING BECOME PROBLEMATIC BECAUSE THE PHYSICIAN WHO REPORTS SERVICES NOT ACTUALLY PERFORMED IS IN DANGER OF COMMITTING AN ACT OF FRAUD.
DEFINITIONS

**COMMISSION**- Occurs when a doctor does something to a patient that other reasonable physicians, in the same area, would not have done

**OMISSION**- Occurs when a doctor neglects to do that which another reasonable physician, in the same area, would do and may potentially harm the patient.

The two major errors of omission are:
1. Failure to diagnose cancer
2. Failure to diagnose related medical conditions

TYPES OF POLICIES

1. **OCCURRENCE**- Pays for acts of omission and commission occurring while the policy was in effect regardless of when the claim is made.

2. **CLAIMS MADE**- Pays during the life of the policy. When discontinuing this type of policy, TAIL COVERAGE should be purchased.

MALPRACTICE INSURANCE PROVIDES

1. Defense in a claim against the doctor
2. An attorney
3. Payment, up to the policy limits
4. Employees are usually covered IF they do not act beyond the scope and course of their duties. Employees must record all patient interactions

**NOTE:** ASSOCIATES ARE NOT COVERED UNLESS NAMED IN THE POLICY. THIS ALSO APPLIES TO A CORPORATION.

IF “UNDER THE INFLUENCE” THE POLICY IS USUALLY VOIDED.

IF CONVICTED OF SEXUAL MOLESTATION THE POLICY IS VOIDED.

When treating someone of the opposite sex:
A. Explain what you are going to do
B. Have a witness of the same gender as the patient
C. Document
D. Use legitimate techniques
DOCTOR’S RESPONSIBILITIES

1. Promptly report claims or suspected claims
2. Cooperate with the insurance company
3. Cooperate with the attorney
4. DO NOT CHANGE OR ALTER RECORDS!!!!!!!!!!

NOTE: 

USUALLY, A MEMBER OF ONE DISCIPLINE (M.D., D.C., D.O., ETC.) MUST TESTIFY AS AN EXPERT IN A MALPRACTICE CASE.

BE WARY OF PATIENTS WHO TELL YOU THAT THEIR PREVIOUS DOCTOR OR HOSPITAL WERE INCOMPETENT

BE WARY OF PATIENTS WHO CHANGE DOCTORS FREQUENTLY OR REPORT THAT THEY HAVE SEEN “LOTS OF DOCTORS” AND NO ONE HAS HELPED

IF THE STAFF TAKES THE INITIAL INTAKE DATA, THE DOCTOR IS STILL RESPONSIBLE

COMMON INJURIES IN MALPRACTICE SUITS

- The most common allegation in musculoskeletal suits is IVD injuries
- The second most common allegation in musculoskeletal suits is fractures
  - Look for pathologies
- CVA’s represents 5% of all malpractice suites
  - Look for risk factors
- Most common allegation in suits involving physical therapy include the use of:
  - Hot
  - Cold
  - Traction

STEPS TO INSULATE YOURSELF AGAINST MALPRACTICE

- Conduct a thorough examination
- Take appropriate, high quality x-rays and provide a written report
- Avoid untested, marginal and experimental techniques and equipment
- DOCUMENT, DOCUMENT, DOCUMENT
• Conduct all parts of George’s test prior to a cervical adjustment
• Institute safety procedures
• Avoid advertising which holds you up to be something that you are not or is a complaint inducing ad
• Have emergency procedures in place (CPR, O2, First Aid, Emergency phone numbers)
• Do not show off or exaggerate
• Regulate your practice and take control
• Have or note valid informed consent to treat (written, verbal or implied)
  A. Nature of procedures
  B. Risks
  C. Probability of risks, if known
  D. Options to treatment (explain to patient)
  E. Risks of no treatment

PROTECTION STRATEGIES

• Avoid giving professional advice in a social situation
• Instruct staff not to give professional advise
• Avoid giving telephone advise, especially to a non-patient
• Give patients proper instructions and DOCUMENT
• Know the law
• Do not work “UNDER THE INFLUENCE”
• Know you patients and discharge “problem” patients
• Maintain confidentiality
• Report child abuse
• Maintain malpractice insurance
• Document all records and perform all NECESSARY tests
• Conduct stroke screening tests prior to cervical adjustments
• Avoid experimental techniques, equipment and procedures
• Scrutinize advertising
• Maintain emergency procedures
• Use sign in sheets
• Keep appropriate notes
• If using a code in note keeping provide the key
• Keep record of informed consent
• Refer when indicated
• Make copies of records available when requested
• Review billing records and make corrections when indicated
• Develop an office procedure manual
• DO NOT ALTER PATIENT RECORDS
• If sued, participate in your own defense
RISK MANAGEMENT

DOCTOR/PATIENT RELATIONSHIP
1. Does not require a contract or written documentation
2. No fee is required
3. Staff can establish a doctor/patient relationship, for you, by giving advice

ESTABLISHING AN EFFECTIVE RISK MANAGEMENT STRATEGY
1. Know the physician’s responsibilities imposed by law
   A. Disciplinary rules established by the regulatory board
   B. Suspected or actual child abuse MUST be reported
   C. Warn a patient if their condition might impair their safe operation of a motor vehicle. If not, the doctor may be held liable by third party (you get sued)
2. If you advertise that you are a diplomat, or that you specialize (difficult cases, sports, orthopedics, neurology, etc), you may be held to a higher standard
3. Case fees may be construed as a warranty
4. When indicated, referrals are MANDATORY or you may be held to the standard of the specialist
5. Generally, a physician is held to the standard of care and skill exercised by a REASONABLE physician (same licensing act) under the same or similar circumstances.
6. Doctor’s or staff members “UNDER THE INFLUENCE” should not be around patients.
7. When advising a patient to exercise, proper instructions should be given and RECORDED in the daily notes.
8. You are subject to breach of contract (written, verbal or implied) if you abandon a patient, guarantee a cure, or exceed the consent given by the patient
9. Keep abreast of changes in the STANDARDS OF CARE. These may come about through:
   A. Statute
   B. Courts
   C. Technology
   D. Colleges
   E. Advertising
INSTRUCTIONS FOR USE OF CURRENT PROCEDURAL TERMINOLOGY (CPT)\textsuperscript{1,2}

BEFORE WE BEGIN A DISCUSSION RELATING TO THE USE OF CPT CODES, IT IS IMPORTANT TO REMEMBER THAT THE CPT CODES WERE DETERMINED BY DOCTORS (MULTI-DISCIPLINARY), FOR DOCTORS (MULTI-DISCIPLINARY). THE TWO STATEMENTS THAT FOLLOW ARE DIRECTLY FROM THE CPT CODE BOOK.

1. The CPT code book\textsuperscript{2} states “A physician using CPT terminology and coding selects the name of the procedure or service that most accurately identifies the service performed. In surgery, it may be an operation, in medicine, an office visit or diagnostic procedure, in radiology, a radiograph. The physician then may list other additional procedures performed or pertinent special services. When necessary, he lists any modifying or extenuating circumstances. \textbf{Any service or procedure should be adequately documented in the medical records.}”\textsuperscript{1}

2. “It is important to recognize that the listing of a service or procedure and its code number in a specific section of this book does not restrict its use to a specific specialty group. Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician.”\textsuperscript{1}

POINTS TO REMEMBER

In order to process a claim, there are certain ground rules which must first be learned and then applied. The goal is to have your claims pass through the system \textit{uninterrupted}.

The application of the information discussed and reviewed in this chapter, will help the physician and his/her support staff (V.I.P’s in the physician’s office) file claims properly and efficiently. The submission of appropriate forms, which are completed properly and are based on ethical, documented, and evidence-based criteria, will lead to maximum reimbursement which is
paid in a timely fashion.

THE PRIMARY GROUND RULE IS:
EACH AND EVERY CODE THAT IS UTILIZED
MUST
BE SUPPORTED BY THE DOCUMENTATION.

NOTE: ALL CPT CODES MAY BE FOUND IN THE AMA'S CPT CODE BOOK. 1
EVALUATION/ MANAGEMENT
(E/M CODES) 1,2

Before embarking on a review of Evaluation and Management Codes (E/M codes) it would be wise to consider the following statement: Document all histories, examination findings, and medical decisions prior to determining the appropriate E/M code. Once the appropriately recorded notes are reviewed, the proper E/M codes may be determined. Remember, all care of a patient, including the E/M service, is predicated on determining and recording the medical necessity for that service.

Generally, it is inappropriate to bill an office visit E/M code on the same visit as a Chiropractic Manipulative Treatment (CMT) code. The reason for this is that CMT codes include a brief pre-manipulation assessment (see pre-intra-post manipulation). It is appropriate when, and only when, an evaluation of a new patient occurs or there are new injuries, exacerbations, or for a periodic re-evaluation (when medically necessary and documented).

There are usually four (4) reasons to do a re-evaluation:

1. The patient is getting better
   A re-examination is indicated so that it may be determined if the frequency of care, or the nature of the care, may be reduced or changed.

2. The patient is getting worse
   A re-examination is indicated so that it may be determined why the patient’s condition is deteriorating despite the care that is being provided. This may indicate that further testing may be necessary, a referral may be indicated, or a change in treatment may be indicated.

3. The patient is staying the same
   A re-examination is indicated so that it may be determined why the patient is not responding to the care that has been prescribed and administered.

4. New injury or exacerbation
   A re-examination is indicated so that it may be determined how the new injury or illness, aggravation or exacerbation of the current injury or illness, has impacted upon the patient.

The following are some areas that should be considered in determining the level of E/M code that is utilized: (See audit requirements for specifics)
1. The chief complaint
2. History of Present Illness (HPI)
3. Past medical history
4. Past family, social history
5. Review of systems
6. Physical examination
7. Review and complexity of data reviewed
8. Clinical impression
9. Tests ordered
10. Treatment options
11. Risks to patients (complexity and complications)

Once all areas noted above have been considered, reviewed, and appropriately documented, a TREATMENT PLAN and TREATMENT GOALS may be determined.

NOTE: EVERYTHING THAT YOU DO, EVERYTHING THAT YOU SAY, AND EVERYTHING THAT YOU CONSIDER, WHEN DETERMINING WHAT TYPE OF HISTORY, EXAMINATION, TEST, PROCEDURE, OR TREATMENT THAT YOU RECOMMEND, REFER, OR PRESCRIBE FOR THE PATIENT, SHOULD BE RECORDED SO THAT THE MEDICAL NECESSITY FOR THAT HISTORY, EXAMINATION, TEST, PROCEDURE, OR TREATMENT MAY BE CLEARLY IDENTIFIED.

TYPES OF PATIENTS1,2

For our purposes, E/M codes are divided into two (2) primary categories:

1. New Patient
2. Established Patient

NEW PATIENT:

“A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years”. When using New Patient E/M codes, three (3) out of three (3) audit requirements are required (see example 1).
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”. When using Established Patient E/M codes, two (2) out of three (3) audit requirements are required (see example 2).2

Example One: A new patient is seen in the office. The history taken is coded as a 99204. The examination meets the criteria for a 99204. The medical decision making is determined to be 99203. The final E/M code for this patient would be 99203. That is the highest level whereby all three audit requirements are met.

Example Two: An established patient is seen in the office. The history is taken is coded as a 99204. The examination meets the criteria for a 99204. The medical decision making is determined to be 99203. The final E/M code for this patient would be 99204. That is the highest level whereby two out of three audit requirements are met.
AUDIT REQUIREMENTS 1,2

KEY ELEMENTS

Although there are seven (7) parts listed to determine the level of E/M service, only three are considered “key” elements.

1. HISTORY
   2. EXAMINATION
   3. MEDICAL DECISION MAKING

CONTRIBUTORY FACTORS

The second set of four (4) elements are considered “contributory”. They are part of the audit requirements, but are not usually areas that are considered when making a determination as to reimbursement requirements. Remember, they are part of the E/M service.

4. Counseling
   A. “Counseling is a discussion with the patient and/or family concerning one or more of the following:
      1. Diagnostic results, impressions, and or recommended diagnostic studies;
      2. Prognosis;
      3. Risks and benefits of management (treatment) options;
      4. Instructions for management (treatment) and/or follow up;
      5. Importance of compliance with chosen management (treatment) options;
      6. Risk factor reduction; and
      7. Patient and family education.”2

5. Coordination of Care
6. Nature of presenting problem
7. Time: It seems that “time” is misunderstood by those who choose to misunderstand it. Time, as defined by CPT “are averages and, therefore, represent a range of times that may be higher or lower depending on actual clinical circumstances.” In other words, it is not how long it takes to obtain information that is pertinent, it is the information that is obtained and pertinent that is important.
NOTE: There is a section within the E/M requirements where “time” is the controlling factor. This occurs “when counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter.” Please note that the information discussed during this encounter MUST be fully documented.
HISTORY

Since the determination of what to do for, and to the patient is determined by a specific course of events, we should look at what is required to make those decisions. The reality is, if you don’t set the foundation correctly, the building is doomed to failure. So, let’s start with the foundation.

Generally speaking, the taking of an appropriate history from the patient, or their legal representative (document who the legal representative is, by name), could give the clinician a clue to the diagnosis in a majority of cases. The appropriate, complete history will also help, IF, the healthcare provider is named in a medical/legal action. It should be noted that, generally, the history should be recorded in the patient’s own words and should tell a story. Do not editorialize or use medical jargon in this section. If the services of a translator are utilized, obtain and record the name of that person. Remember, the information obtained in the history will lead to the other “key” component audit requirements (examination and medical decision making).

The history is comprised of THREE parts. For the purpose of this discussion, we will divide this section into the following categories:

**HISTORY OF PRESENT ILLNESS (HPI)**

“A chronological description of the development of the patient’s present illness from the first sign and/or symptom to the present.2

**REVIEW OF SYSTEMS (ROS)**

**PAST, FAMILY, SOCIAL HISTORY (PFSH)**
HISTORY OF PRESENT ILLNESS (HPI)

NATURE OF THE PRESENTING PROBLEM

A. Complaint
B. Disease
C. Condition
D. Illness
E. Injury
F. Symptom
G. Sign
H. Finding
I. Other

TYPES OF PRESENTING PROBLEMS

A. Minimal:
   Nature of problem is extremely limited
B. Self-limited:
   The problem usually runs a specific course and the probability is that a full recovery will be made
C. Low:
   Little or no risk to the patient with no expected residual problems
D. Moderate:
   The risk to the patient is increased without treatment and the prognosis is uncertain, with possible residual problems
E. High:
   The risk to the patient is significant without treatment and the prognosis is guarded, with probable residual problems

PATIENT COMPLAINTS (HPI)

A. Location:
   Where is the problem? (arms, legs, neck, side etc.)
B. Quality:
   Description of the problem. (burning, itching, tingling, etc.)
C. Severity:
   How intense is the problem? (mild, moderate, severe, etc.)
   NOTE: A 1-10 pain scale may be used to determine and
quantify the severity of pain

D. Duration:
   How long has the problem been present? (today, yesterday, last night, etc.)

E. Timing:
   When does the problem occur? (standing, sitting, etc.)

F. Context:
   In what instances does the problem occur? (sitting to standing, sitting for long periods of time, etc.)

G. Modifying Factors:
   What makes the problem better or worse? (ice, heat, rest, etc.)

H. Associated Signs And Symptoms:
   Other problems associated with the Chief Complaint. (cold aggravates problem, stress, etc.)

Note: When reviewing the patients’ complaints, the following information may be of assistance:

<table>
<thead>
<tr>
<th>Letter</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>Onset</td>
</tr>
<tr>
<td>P</td>
<td>Palliative</td>
</tr>
<tr>
<td>Q</td>
<td>Quality</td>
</tr>
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<td>S</td>
<td>Severity</td>
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<td>T</td>
<td>Treatment</td>
</tr>
<tr>
<td>L</td>
<td>Location</td>
</tr>
</tbody>
</table>
NOTE: There appears to be nothing in the literature that describes the manner in which the “Review of Systems” must be conducted. It is the information obtained and recorded that is important, not the manner in which that information is obtained.

NOTE: The ROS helps define the problem, clarify the differential diagnosis (evaluating any number of possible co-morbidities presenting with similar symptoms), and identify needed testing or services as baseline data. The data obtained in the ROS may provide information that would impact on management options and decisions.

1. Constitutional:
   Height, weight, blood pressure, etc.
2. Eyes:
   Changes in vision, pain, burning, itching, etc.
3. Ears, Nose, Mouth, and Throat:
   Ringing in the ears, bloody nose, blisters in the mouth, problems with swallowing, etc.
4. Cardiovascular:
   Rapid heat rate, chest pain, swelling, etc.
5. Respiratory:
   Difficulty breathing, chest pain, coughing, etc.
6. Gastrointestinal:
   Blood in stool, irritable bowel, pain in the stomach, etc.
7. Genito-urinary:
   Changes in urinary pattern, blood in urine, pain, sexual dysfunction, discharge, etc.
8. Musculoskeletal:
   Joint pain, back pain, leg pain, neck pain, cramps, spasm, etc.
9. Integumentary:
   Skin problems (itching, burning, rashes, soreness, etc.)
10. Neurologic:
    Headaches, dizziness, balance, numbness, etc.
11. Psychiatric:
    Personality changes, cognitive, etc.
12. Endocrine:
    Thyroid, glands, thirst, weight changes, etc.
13. **Hematologic/Lymphatic:**
   Bleeding, swelling, bruises, etc.

14. **Allergic/Immunologic:**
   Immune disorders, allergies, nasal discharge, etc.

**PAST, FAMILY, SOCIAL HISTORY (PFSH) \(^1,2\)**

**Family History:**
“A review of medical events in the patient’s family that includes significant information about:

a. The health status or cause of death or parents, siblings, and children;
b. Specific diseases related to problems identified in the chief complaint or history of the present illness, and/or system review;
c. Diseases of family members which may be hereditary or place the patient at risk.”\(^2\)

**Past History:**
“A review of the patient’s past experiences with illness, injuries, and treatments that includes the following:

a. Prior major illnesses and injuries;
b. Prior operations;
c. Prior hospitalizations;
d. Current medications;
e. Allergies
f. Age appropriate immunization status
g. Age appropriate feeding/dietary status.”\(^2\)

**Social History:**
“An age appropriate review of past and current activities that includes the following:
a. Marital status and/or living arrangements;
b. Current employment; training, experience, length of employment;
c. Use of drugs, alcohol, and tobacco;
d. Sexual history;
e. Other relevant social factors.”
f. Occupation
   1. Education
   2. Training
   3. Military

**HOW TO DETERMINE WHICH HISTORY LEVEL SHOULD BE USED**

The decision of which history level should be used is determined by the clinical judgment of the provider and nature of the patient’s presenting problem(s). There is no “cookbook” approach to taking a proper history. The history level will unfold as information is obtained. In short, the taking of a history is like putting the pieces of a puzzle together. One piece fits into another until the entire picture is revealed.

**HISTORY LEVELS**

**PROBLEM FOCUSED:**
1. CHIEF COMPLAINT
2. BRIEF HISTORY OF PRESENT ILLNESS OR PROBLEM
3. NO PFSH IS REQUIRED

**EXPANDED PROBLEM FOCUSED:**
1. CHIEF COMPLAINT
2. BRIEF HISTORY OF PRESENT ILLNESS
3. PROBLEM PERTINENT (SYSTEM DIRECTLY RELATED TO PROBLEM IDENTIFIED IN THE HPI) SYSTEM REVIEW
4. NO PFSH IS REQUIRED
DETAILED:
1. CHIEF COMPLAINT
2. EXTENDED HISTORY OF PRESENT ILLNESS
3. PROBLEM PERTINENT SYSTEM REVIEW EXTENDED TO INCLUDE A REVIEW OF A LIMITED NUMBER OF ADDITIONAL SYSTEMS
4. PERTINENT PAST, FAMILY AND/OR SOCIAL HISTORY DIRECTLY RELATED TO THE PATIENT’S PROBLEMS

COMPREHENSIVE:
1. CHIEF COMPLAINT
2. EXTENDED HISTORY OF PRESENT ILLNESS
3. REVIEW OF SYSTEMS WHICH IS DIRECTLY RELATED TO THE PROBLEM(S) IDENTIFIED IN THE HISTORY OF THE PRESENT ILLNESS PLUS A REVIEW OF ALL ADDITIONAL BODY SYSTEMS
4. COMPLETE PAST, FAMILY, AND SOCIAL HISTORY

SAMPLE NOTES

It should be noted that all notes should be legible and contain enough information to justify the doctor’s course of care. The notes should tell a story and should allow any other health care provider, third party payer, attorney or court to understand the rationale for the care that has been provided for the benefit of the patient.

The following are ONLY suggestions. It is up to the provider to submit records which adhere to state board requirements and acceptable standards of care.

PROBLEM FOCUSED:

A 35 year old male entered the office today reporting that yesterday, while playing football, he “jammed” the “forefinger” of his right hand. He said, after the game he applied ice, but, continues to have some swelling and pain.

Chief complaint: Swelling and pain of forefinger of right
Brief history: He was playing football yesterday and jammed his finger.

EXPANDED PROBLEM FOCUSED:

A 35 year old male entered the office today reporting that yesterday, while playing football, he “jammed” the “forefinger” of his right hand. He said, after the game he applied ice, but, he has some swelling and pain. He also reported that when he moves his wrist, the pain increases. He said he cannot bend his finger. He reported there was no tingling in the finger or hand.

Chief complaint(s): Swelling and pain in the forefinger of right hand.

Brief history: He was playing football yesterday and jammed his finger.

Problem pertinent system review: Pain increases with movement of wrist. He cannot bend the finger. There was no tingling in the finger or hand.

PFSH: N/A

DETAILED:

A 35 year old male entered the office today reporting that yesterday, while playing football, he “jammed” the “forefinger” of his right hand. He also reported that he felt a “pulling on the right side of his neck.” He said, after the game he applied ice, but, he continues to have some swelling and pain. He also reported when he moves his right wrist, the pain increases and he cannot bend his finger. He said that the pulling in his neck increases when he turns to the left and causes some tingling into his right upper arm. Upon questioning, the patient reported that his father has a history of arthritis and “pinched nerves” in his lower back.

Chief complaint(s): Swelling and pain in the forefinger of right hand with pulling in the neck on the right side.
**Extended history:**

Patient was playing football and jammed his finger. He also felt a pulling in the neck. Movement of the wrist increases pain and he cannot bend his finger. Turning of his head, to the left, increases pain and causes tingling into the right upper arm.

**Problem pertinent system review:** Musculoskeletal, Neurologic, Lymphatic, Integumentary

**PFSH:**

Father has a history of arthritis and “pinched nerves”

**COMPREHENSIVE:**

A 35 year old male entered the office today reporting that yesterday, while playing football, he “jammed” the “forefinger” of his right hand. He also reported that he felt a “pulling in his neck” on the right side. He said, after the game he applied ice, but, he continues to have some swelling and pain. He also reported that when he moves his right wrist, the pain increases and he cannot bend his finger. He said that the pulling in the neck increases when he turns to the left and causes some tingling into the right upper arm. He also said that after he was hit, he noticed some pressure in his chest and pain when he takes a deep breath. He said that he has also had to urinate more frequently than usual and that he has had a low grade headache on the left side (he pointed to the area of the left temple). On further questioning, the patient reported that his father has a history of arthritis and “pinched nerves”. He also said that his father had a “mini stroke” a number of years ago with no present problems. He stated that his mother has a history of “emphysema” and quit smoking about 3 years ago. The patient denied a history of smoking and drinks alcohol 1-2 times per month. He said he takes no medication and has no history of any surgery.

**Chief complaint(s):**

Swelling and pain of the forefinger of right hand with pulling in the neck, right side. Chest pressure and pain. More frequent urination and headaches.

**Extended history:**

Patient was playing football and jammed his
finger on the right. He also felt a pulling in the neck. Movement of the wrist increases pain and he cannot bend his finger. Turning the head to the left increases pain and results in tingling that radiates into the right upper arm. The patient reported chest and rib pain when he takes a deep breath. The patient said that he had increased frequency of urination, and headaches.

**Review of systems:**
Musculoskeletal, Neurologic, Lymphatic, Integumentary, Cardiovascular, Genito-urinary

**PFSH:**
Father has a history of arthritis and “pinched nerves”. His father also has a history of a “mini stroke” with no present problems reported. The patient’s mother has a history of smoking and emphysema. He denies taking medication and has no history of surgery.
# HISTORY REVIEW

<table>
<thead>
<tr>
<th>TYPE LEVEL</th>
<th>HIP</th>
<th>ROS</th>
<th>PFSH</th>
<th>HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRIEF FOCUSED</td>
<td>1-3 ELEMENTS</td>
<td>N/A</td>
<td>NONE</td>
<td>PROBLEM</td>
</tr>
<tr>
<td>BRIEF</td>
<td>1+3 ELEMENTS</td>
<td>PROBLEM PERTINENT</td>
<td>NONE</td>
<td>EXPANDED PROBLEM FOCUSED</td>
</tr>
<tr>
<td>EXTENDED</td>
<td>4 OR MORE ELEMENTS</td>
<td>EXTENDED*</td>
<td>PERTINENT*</td>
<td>DETAILED</td>
</tr>
<tr>
<td>EXTENDED</td>
<td>4 OR MORE</td>
<td>COMPLETE*</td>
<td>COMPLETE*</td>
<td>COMREHEN.</td>
</tr>
</tbody>
</table>

*SEE DEFINITIONS*
EXAMINATION 1,2

Before making a determination as to the type or level of examination that is to be performed, a review of the history, including the HPI (History of Present Illness), ROS (Review of Systems), and PFSH (past, family, social history) should be considered. A review of the HPI, ROS and PFSH will help establish the medical necessity for the physical examination: All information should be documented.

Basically, there are 4 (four) types of examinations that may be performed. They are:

1. PROBLEM FOCUSED:
   Limited to a body area or organ system

2. EXPANDED PROBLEM FOCUSED
   Limited to a body area or organ system and other symptomatic or related organ system(s)

3. DETAILED
   Extended exam or the affected body area(s) and other symptomatic or related organ system(s) (more depth than Expanded Problem Focused Level)

4. COMPREHENSIVE
   Complete exam of a single system or general multi-system

PLEASE REVIEW THE FOLLOWING SPECIAL NOTES:

1. Abnormal exam findings should be documented and identified as such.
2. Normal exam findings should be documented and identified as such
3. Do not leave empty spaces on the examination form.
   Use appropriate notations in each area examined.
4. Examples of notations for empty spaces:
   a. WNL: within normal limits
   b. N/A: not applicable
   c. N/A/A: no apparent abnormalities
5. A review of the vital signs should always be included and quantifiably documented because, as the physician, you have a responsibility to ensure the safety and well being of the patient. Your responsibility extends to determining whether or not the patient’s condition is within your area of expertise or a specialist referral is in order. The information obtained in this area is a contributing factor in the differential diagnosis.

MULTI-SYSTEM EXAMINATION

In keeping with the requirements of all physical examinations, the Multi-System Examination is divided into the following sections:

PROBLEM FOCUSED: Requires a minimal number of areas to be covered in one or more organ system(s) or body area(s)

EXPANDED PROBLEM FOCUSED: Requires an increased number of areas to be covered in one or more organ systems(s) or body area(s)

DETAILED: Requires at least six (6) organ systems or body areas to be examined. In each system, a number of items must be examined

COMPREHENSIVE: Requires at least nine (9) organ systems or body areas to be examined. All areas of each system must be addressed.

SINGLE SYSTEM EXAMINATION

As with a Multi-System Examination, the examination involving a Single System is divided into the following sections:

PROBLEM FOCUSED: Requires a minimal number of areas to be covered

EXPANDED PROBLEM FOCUSED: Requires at least six (6) elements be addressed in a limited number of systems

DETAILED: Requires at least twelve (12) elements be addressed in a
limited number of systems

**COMPREHENSIVE:** Requires all elements be addressed

*NOTE:* When discussing body areas, organ systems, elements, etc., “CHIROPRACTIC CODING SOLUTIONS MANUAL” published by the ACA (American Chiropractic Association) should be referred to. Please note that this book is updated by the “Coding and Reimbursement Committee” of the ACA every year. The AMA’s “CPT, PROFESSIONAL EDITION” may also be consulted. It is also published and updated every year.
**MEDICAL DECISION MAKING**

This is an area where most physicians seem to fall short. The documentation does not address the rationale behind the testing, procedure, diagnostic and treatment decisions.

<table>
<thead>
<tr>
<th>TYPE OF DECISION MAKING</th>
<th>AMOUNT AND/OR COMPLEXITY OF DATE REVIEWED</th>
<th>RISK OF COMP.</th>
<th>NUMBER OF DX. DX. OR MGT. OPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight Forward</td>
<td>Minimal or None</td>
<td>Minimal (1 self limited or minor problem)</td>
<td>Minimal (self limited or minor problem)</td>
</tr>
<tr>
<td>(1 element)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Low (2 or more self limited problems)</td>
<td>Limited (est. problem which is worsening)</td>
</tr>
<tr>
<td>(2 elements)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Moderate</td>
<td>Moderate (one or more chronic problems with mild exacerbation, 2 or more stable problems, undiagnosed new problem, acute problem, acute complicated problem)</td>
<td>Multiple (new problem with no additional work up planned)</td>
</tr>
<tr>
<td>(3 elements)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extensive (High)</td>
<td>Extensive</td>
<td>Extensive (one or more problems with severe exacerbation, an acute or chronic problem that may pose a threat to life or body function, an abrupt change in Neurologic status)</td>
<td>Extensive (new problem, new work up planned)</td>
</tr>
<tr>
<td>Complexity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4 or more Elements)*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*ELEMENTS OF COMPLEXITY

1. IF A DIAGNOSTIC SERVICE (TEST OR PROCEDURE) IS ORDERED, PLANNED, SCHEDULED, OR PERFORMED AT THE SAME TIME AS THE E/M ENCOUNTER, THE TYPE OF SERVICE SHOULD BE DOCUMENTED

2. THE REVIEW OF THE DIAGNOSTIC TEST SHOULD BE DOCUMENTED. “CHEST X-RAY UNREMARKABLE” IS ACCEPTABLE. LAB REPORTS MAY BE INITIALED AND DATED

3. DECISION TO OBTAIN OTHER RECORDS OR ADDITIONAL HISTORY FROM ANOTHER SOURCE SHOULD BE DOCUMENTED

4. RELEVANT FINDINGS FROM REVIEW OF OLD RECORDS AND/OR ADDITIONAL HISTORY. IF NO RELEVANT INFORMATION IS OBTAINED THEN “OLD RECORDS REVIEWED” IS ADEQUATE. RELEVANT FINDINGS SHOULD BE NOTED

5. RESULTS OF DISCUSSIONS OF DIAGNOSTIC TESTS WITH THE PHYSICIAN WHO PERFORMED THE TEST SHOULD BE NOTED WITH DATE AND TIME

6. DIRECT VISUALIZATION OR INDEPENDENT INTERPRETATION OF AN IMAGE OR TEST ALSO INTERPRETED BY ANOTHER PHYSICIAN SHOULD BE NOTED
### E/M Codes: New Patient

(NO SERVICES FOR THE PATIENT WITHIN THE PAST THREE YEARS)
(AUDIT REQUIREMENTS: 3 OF 3)

<table>
<thead>
<tr>
<th>Code</th>
<th>Level</th>
<th>History Description</th>
<th>Examination Description</th>
<th>MDM Complexity</th>
<th>Average Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>LEVEL I</td>
<td>PROBLEM FOCUSED</td>
<td>PROBLEM FOCUSED</td>
<td>STRAIGHT FORWARD</td>
<td>10 MINUTES</td>
</tr>
<tr>
<td>99202</td>
<td>LEVEL II</td>
<td>EXPANDED PROBLEM FOCUSED</td>
<td>EXPANDED PROBLEM FOCUSED</td>
<td>STRAIGHT FORWARD</td>
<td>20 MINUTES</td>
</tr>
<tr>
<td>99203</td>
<td>LEVEL III</td>
<td>DETAILED</td>
<td>DETAILED</td>
<td>LIMITED</td>
<td>30 MINUTES</td>
</tr>
<tr>
<td>99204</td>
<td>LEVEL IV</td>
<td>COMPREHENSIVE</td>
<td>COMPREHENSIVE</td>
<td>MODERATE</td>
<td>40 MINUTES</td>
</tr>
<tr>
<td>99205</td>
<td>LEVEL V</td>
<td>COMPREHENSIVE</td>
<td>COMPREHENSIVE</td>
<td>HIGH</td>
<td>60 MINUTES</td>
</tr>
</tbody>
</table>
# E/M CODES:
## ESTABLISHED PATIENT

(AUDIT REQUIREMENTS: 2 OF 3)

<table>
<thead>
<tr>
<th>Code</th>
<th>Level</th>
<th>History</th>
<th>Examination</th>
<th>Complexity of MDM</th>
<th>Average Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>LEVEL I</td>
<td>MINIMAL</td>
<td>MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN</td>
<td>N/A</td>
<td>5 MINUTES</td>
</tr>
<tr>
<td>99212</td>
<td>LEVEL II</td>
<td>PROBLEM FOCUSED</td>
<td>LIMITED</td>
<td>STRAIGHT FORWARD</td>
<td>10 MINUTES</td>
</tr>
<tr>
<td>99213</td>
<td>LEVEL III</td>
<td>EXPANDED PROBLEM FOCUSED</td>
<td>EXPANDED PROBLEM FOCUSED</td>
<td>LOW</td>
<td>15 MINUTES</td>
</tr>
<tr>
<td>99214</td>
<td>LEVEL IV</td>
<td>DETAILED</td>
<td>DETAILED</td>
<td>MODERATE</td>
<td>25 MINUTES</td>
</tr>
<tr>
<td>99215</td>
<td>LEVEL V</td>
<td>COMPREHENSIVE</td>
<td>COMPREHENSIVE</td>
<td>HIGH</td>
<td>40 MINUTES</td>
</tr>
</tbody>
</table>
It is impossible to pre-determine what level of service should be provided to a patient, until the physician actually speaks to the patient. With this thought in mind, a flow chart may be of some help.

**Flow Chart**

Whenever possible, confirm insurance coverage prior to the patient entering the office.

The history level cannot be determined prior to the patient entering the office. As the history is being taken (in the patient’s own words), the level is determined by what they tell you and what follow up questions you ask.

A **HISTORY** is taken which includes:
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past, Family, Social History (PFSH)

The level of examination is determined by the history.

The medical decision making is determined by the history and examination. The number of decisions, and the risks to the patient, help to determine the care provided to the patient.

The tests ordered for the patient, and the medical necessity for those tests are determined by the history, examination, and medical decision making.

Whatever procedures are determined to be necessary for the patient, are based on the history, examination, medical decision making, and test results. As always, it is necessary to establish the medical necessity for everything that you do to, and for, the patient.

Without establishing the proper foundation, no treatment may be rendered.
CONSULTATIONS 1,2

By definition, “a consultation is a type evaluation and management service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient’s entire care or for the care of a specific condition or service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.” 2

The AMA guides defines an appropriate source as a “physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech-language pathologist, psychologist, social worker, lawyer, or insurance company” 2

“The written or verbal request for a consult may be made by a physician or other appropriate source and documented in the patient’s medical record. The consultant’s opinion and any services that were ordered or performed must also be documented in the patient’s medical record and communicated by written report to the requesting physician or other appropriate source.” 2

“A consultation initiated by a patient and/or family, and not requested by a physician or other appropriate source…, is not reported using the consultation codes but may be reported using the office visit, home service, or domiciliary /rest home care codes, as appropriate.” 2

“The consultant’s opinion and any services that were ordered or performed must also be documented in the patient’s medical record and communicated by written report to the requesting physician or other appropriate source.” 2

“If a consultation is mandated, e.g., by a third-party payer, modifier -32 should also be reported.” 2
OFFICE OR OTHER OUTPATIENT CONSULTATIONS 1,2
(NEW OR ESTABLISHED PATIENT)

NOTE: The following codes are, primarily, used to report consultations provided in the physician’s office or other outside source. The codes are the same for new and established patients and require three (3) out of three (3) audit requirements.

**99241**
1. PROBLEM FOCUSED HISTORY
2. PROBLEM FOCUSED EXAMINATION
3. STRAIGHTFORWARD MDM

**99242**
1. EXPANDED PROBLEM FOCUSED HISTORY
2. EXPANDED PROBLEM FOCUSED EXAM
3. STRAIGHTFORWARD MDM

**99243**
1. DETAILED HISTORY
2. DETAILED EXAMINATION
3. LOW COMPLEXITY MDM

**99244**
1. COMPREHENSIVE HISTORY
2. COMPREHENSIVE EXAMINATION
3. MODERATE COMPLEXITY MDM

**99245**
1. COMPREHENSIVE HISTORY
2. COMPREHENSIVE EXAMINATION
3. HIGH COMPLEXITY MDM

The requirements noted above are the KEY components (does not include time). As mentioned previously, counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem (s) and the patient’s and/or the family/s needs.
ADDITIONAL CODES

NOTE: It is most important that the medical necessity for each of these codes be identified in the medical records.

99050
Services provided in the office at times other than regularly scheduled office hours, or day when the office is normally closed (e.g. holidays, Saturday or Sunday), in addition to basic service.

99056
Services typically provided in the office, provided out of the office at request of patient, in addition to basic service.

99058
Services provided on an emergency basis, in the office, which disrupts other scheduled office services, in addition to basic service.

99060
Services provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service.

99070
Supplies and material (except spectacles) provided by the physician over and above those usually included with the office visit or other services rendered. NOTE: To increase specificity, refer to the AMA’s HCPCS book.

99071
Educational supplies, such as books, tapes, and pamphlets, provided by the physician, for the patient’s education at cost to the physician.

99075
Medical Testimony

99082
Unusual travel (e.g. Transportation and escort of a patient).
RANGE OF MOTION TESTING AND MUSCLE TESTING (95831-95857)

It should be noted that muscle testing and range of motion testing are part of the evaluation and management codes. They are an integral part of codes (99201-99215, 99211-99215, etc). While there is nothing wrong with using codes (95831 and 95851), the medical necessity for the use of these codes, outside of the E/M codes, must be established and documented.

95831
Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk.

95832
Hand, with or without comparison with the normal side.

95833
Total evaluation of body, excluding hands.

95834
Total evaluation of body, including hands.

95851
Range of motion, measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine).

95852
Hand, with or without comparison with the normal side.

Remember there are ethical, as well as legal, repercussions of using CPT coding. The use of the codes, are not to be taken lightly. They have an impact on the patient, as well as the healthcare provider.
CMT CODES

98940  1 - 2  Regions of the spine
98941  3 - 4  Regions of the spine
98942  5  Regions of the spine

98943  Extra-spinal: One or more regions

NOTE: No matter how many extra-spinal areas are treated on the same day, you only bill this code once. You do report every area treated.

SPINAL REGIONS

CERVICAL:  C1-C7: Includes the Atlanto-Occipital Joint

THORACIC:  T1-T12: Includes the Costo-Vertebral and Costo-Transverse Joints (Posterior Ribs)

LUMBAR:  L1-L5

SACRAL  Includes: Sacro-coccygeal junction

PELVIC  Includes: Sacro-iliac joint

EXTRASPINAL REGIONS

HEAD  Includes: Tempromandibular Joint

LOWER EXTREMITIES  Includes: Hip, Knee, Ankle, Foot, and Toes

UPPER EXTREMITIES  Includes: Shoulder, Elbow, Wrist, Hand, and Fingers

RIB CAGE  Includes: Costo-Sternal Junction (Anterior Ribs)

ABDOMEN
The “work per unit of time”, or work value or CPT codes in general, are based not only on the amount of time spent with a patient, but also the amount of work (including physician skill and judgment) required during the visit. This work per unit of time is divided into three sections.

1. Pre-Service
2. Intra-Service
3. Post-Service

**PRE-SERVICE: Work/Time before the patient arrives or the service is performed**

1. Review of clinical data which has already been obtained
2. Documentation and chart review
3. Imaging review
4. Test interpretation
5. Care Planning

**INTRA-SERVICE: Work/Time with the patient (face-to-face) or during the service**

1. Patient preparation
2. Pre-Manipulation (palpation, etc.)
3. Manipulation (performance of the adjustment)
4. Post-Manipulation (patient assessment)
5. Re-adjustment, if necessary
6. Post adjustment instructions to the patient

**POST-SERVICE: Work/Time after the patient leaves the office or after the service**

1. Chart documentation
2. Consultations and communication
3. Reporting
4. Care Planning
5. Review of literature
MODIFIERS 1.2.3.4

(A MODIFIER IS THE MEANS BY WHICH THE PROVIDER MAY COMMUNICATE WITH THE THIRD PARTY PAYER THAT AN ALTERATION IN THE STANDARD WORK PROCESS HAS OCCURRED. THE THREE PRIMARY MODIFIERS USED IN THE PHYSICIANS OFFICE ARE LISTED BELOW)

-25

SIGNIFICANT, SEPARATELY IDENTIFIABLE EVALUATION AND MANAGEMENT SERVICE BY THE SAME PHYSICIAN ON THE SAME DAY OF THE PROCEDURE OR OTHER SERVICE: When a physician needs to indicate that on a day that a procedure was performed, which is identified by a CPT code, the patient’s condition required a significant, separately identifiable E/M service above and beyond the usual pre and post service associated with the service.

An established patient with an acute, significant exacerbation of symptoms or an aggravation which requires a new or updated examination. When an E/M service is provided on the same date as a CMT service, the modifier is attached to the E/M CPT code.

EXAMPLE: 98940, 99213-25

-52

REDUCED SERVICES: When a service or procedure is partially reduced or eliminated, at the physician’s discretion, this modifier is used.

EXAMPLE
97124-52 (massage of the left thigh): The use of the -52 modifier indicates that the service that was performed may be to a limited area and the service was not as usually reported.

(NOTE: THIS IS USUALLY USED WITH A TIMED THERAPEUTIC PROCEDURE CODE)
DISTINCT PROCEDURAL SERVICE: When there is a need to indicate that a procedure or service was performed which is distinct or independent from other services performed on the same day, this modifier is used. This is only used if there are no other modifiers that are more descriptive.

EXAMPLE: 98941, 97140-59

REFERENCES
2. “ACA’s Chiropractic Coding Solutions Manual”, American Chiropractic Association
3. “Coding with Modifiers”, American Medical Association
4. “Understanding Modifiers”, Ingenix Coding Lab
PHYSICAL MEDICINE AND REHABILITATION

As previously mentioned, numerous times, there is a part of physical medicine and rehabilitation that encompasses the topic of ethics. It must always be remembered that the patient’s needs are paramount, and the needs of the provider do not enter into the decision of whether or not to include these services in the care of the patient. Again, medical necessity is the basis by which these services are provided.

If you are referring to, or personally performing physical medicine services, you must first establish the medical necessity for those activities. The most appropriate and efficient manner to establish medical necessity is by using evidence based references.

Rehabilitation is generally measured by the therapeutic outcomes experienced by the patient, in relation to function (defined in Dorland’s Medical Dictionary as “the special, normal, or proper physiologic activity of an organ or part”). Therefore, it is very important to establish and set the treatment goals and parameters.

Evidence based documentation is related to the most current research by “accepted” authorities (accepted in this instance refers to credentialed researchers that follow scientific protocols, and provide as objective measures). The nature of the research should be identified and the manner in which the information was obtained should also be identified. The information used by the provider of services should be tempered and balanced by the expertise of that provider along with the needs of the patient.

It should be remembered that, as in chiropractic, rehabilitation also has a number of roadblocks related to research. By this, I mean that the normal “double blind” type studies cannot always be done when working with hands on treatment. “Scientific evidence needed to perform a review and make an evidence-based decision is frequently inadequate or unavailable.” This is due mainly to the nature of the procedures, the skill of the examiners and the participation of the patient.
**MODALITIES:** Generally, modalities are modes of treatment which are applied to a patient and do not require the participation of the patient.\(^{11}\)

**SUPERVISED:** Does not require one-on-one contact by the provider or therapist. Billing is permitted on time per encounter (it does not matter how many areas are treated).

**EXAMPLES:**
- Hot and Cold Packs
- Unattended Electrical Muscle Stimulation
- Mechanical Traction

**CONSTANT ATTENDANCE:** Requires one-on-one contact by the provider or therapist and is reported in 15 minute “units” increments.\(^{13}\)

**EXAMPLES:**
- Ultrasound
- Manual Electrical Stimulation
- Therapeutic Procedures

**THERAPEUTIC PROCEDURES:** Generally, therapeutic procedures are attended and timed. They usually require the active participation of the patient. Procedures may be reported for on-on-one physician or therapist contact or in a group. If in a group, a separate CPT is used.

**TIMED CODES:** Timed codes are usually Therapeutic Procedures, however, there are a number of Modalities that are also timed. Whether procedures or modalities, when they are timed, they are handled the same. It is recommended that the time you spend with the patient be recorded. Generally, the timed codes include all three of the aspects of the service encounter (pre, intra, and post service). There is an exception to this, and that is when the service is provided under Medicare. In that case, only the actual time spent by the provider, with the patient (intra-service), is counted.

**NOTE:** It is important to remember that these services require constant (DIRECT) attendance by the provider or therapist. That means ONE-ON-ONE contact. If the provider or therapist is providing care for more than one patient, CPT code 97150 should be used.
NOTE:

EXAMPLES OF DOCUMENTARY NOTES FOR PHYSICAL THERAPY FOLLOW EACH LISTED MODALITY AND PROCEDURE. THEY ARE PROVIDED, ONLY, AS EXAMPLES OF RECORD KEEPING/DOCUMENTATION NOTES TO ESTABLISH THE MEDICAL NECESSITY FOR PHYSICAL THERAPY. THEY ARE NOT INTENDED TO BE USED EXACTLY AS WRITTEN. PATIENT NOTES SHOULD BE SPECIFIC TO THAT PATIENT AND THEIR CONDITION FOR EACH ENCOUNTER. THEY NEED NOT BE VERBOSE, BUT,WHENEVER POSSIBLE, SPECIFIC TO THE POINT, AND AS QUANTIFIABLE AS POSSIBLE.

MODALITIES  

97010

**HOT OR COLD PACKS**

(HOT) *Relax spasm*

(COLD) *Relieve pain and reduce muscle spasm*

**HOT**

*Increase vasodilation rates*

*Increase local circulatory rates*

*Produce sedation and local analgesia*

*Slight increase in local metabolism*

**COLD**

*Decrease blood flow to the areas of acute inflammation*

*Reduce swelling*

*Produce sedation and local analgesia*

*Decrease in local tissue metabolism*

**HOT/COLD**

Cold: Cold is generally applied in an attempt to reduce inflammation by cooling the body tissue thereby causing a vasoconstriction and decreasing tissue metabolism. Pain and swelling reduction is also the desired effect.
**Heat:** Heat is generally applied in an attempt to decrease pain and relax the tissue. In doing so, it also helps decrease muscle spasm and joint stiffness. This will result in increased muscle relaxation and flexibility.7

97012

**MECHANICAL TRACTION**

*Articular jamming
*Joint hypo-mobility
*Peri-vertebral fixations
*Spasticity
*Spinal nerve root impingement
*Splinting effect of sprains

**MECHANICAL TRACTION**

Mechanical traction is applied to separate and stretch the spinal segments. It is also applied to promote distraction and gliding of the joint facets. It is further used to dissipate edema as a result of the movement involved in this modality. The alternating pull and relaxation helps to promote joint hydration.4

97014

**LOW FREQUENCY THERAPY**

**Electrical Stimulation (Unattended)**
*Adhesions
*Edema
*Muscle spasm
*Pain
*Trigger points
*Passive exercise

**High Volt Therapy**
*Pain
*Muscle spasm
*Edema

**Microcurrent Therapy**
*Post traumatic inflammation
*Swelling
*Wound healing

ELECTRICAL STIMULATION (UNATTENDED)

Low Volt Electrical Muscle Stimulation:
LVMS is used to reduce edema, adhesions and muscle spasm. It also has a positive effect on pain and provides passive exercise and relaxes the tissue.

High Volt Electrical Muscle Stimulation:
HVMS is used to reduce pain and muscle spasm. It also helps to reduce inflammation and promote tissue healing and repair.

Low Frequency Therapy:
Low frequency therapy helps with the reduction of post traumatic inflammation, reduces swelling and promotes wound healing.

97016
INTERFERENTIAL THERAPY**
VASOPNEUMATIC DEVICES

*Acute and chronic pain
*Muscle strengthening
*Spasm reduction
*Edema reduction

VASOPNEUMATIC DEVICE/INTERFERENTIAL THERAPY

Interferential therapy is used to affect deep seated musculoskeletal problems. It has a beneficial effect on both acute and chronic pain. It also has the effect of helping to strengthen muscles, tendons and ligaments.

97018
PARAFFIN

*Non acute arthritic joints, especially with limited mobility
*Strains
*Sprains
*Contractures that limit motion
PARAFFIN

Paraffin is used to help introduce superficial heat to the tissue which helps increase mobility of arthritic joints as well as reduce stiffness, strains and sprains.

97022

WHIRLPOOL HOT OR COLD
* Increase circulation
* Increase mobility
* Relaxation
* Analgesia or sedation
* Promote tissue healing
* Relax muscle spasm

97024

DIATHERMY (e.g., MICROWAVE)
* Deep heat over a broad area
* Analgesia
* Sedation

NOTE: WHEN USING DIATHERMY, IT IS APPROPRIATE TO SPECIFICALLY STATE THAT THE AREA WAS DRY AND TOWELS WERE PLACED IN APPROPRIATE AREAS TO ELIMINATE SWEATING. IT IS ALSO APPROPRIATE TO STATE THAT ALL METAL OBJECTS WERE REMOVED FROM THE TREATMENT AREA.

NOTE: THE FOLLOWING MODALITIES REQUIRE CONSTANT ATTENDANCE.

97032

APPLICATION OF MODALITIES
EMS (manual) each 15 minutes to one or more areas
IONTOPHORESIS
(EACH 15 MINUTES)
*Acute trauma
*Adhesions
*IVD Syndromes
*Neuritis
*Sprains
*Strains

CONTRAST BATHS
(EACH 15 MINUTES)
*Hot water (98-112 degrees, F)
*Cold water (60-75 degrees, F)
*Acute musculoskeletal injuries
*Promotes healing

ULTRASOUND
CONTINUOUS
*Heat
*High intensity micro-massage
*Relaxes muscles
*Chronic inflammation

PULSED
*Pain

ULTRASOUND
“Therapeutic US produces thermal and nonthermal effects. Thermal effects include increased collagen extensibility, alterations in blood flow, changes in nerve conduction velocity, increased cell membrane permeability, increased tissue metabolism, and increased pain threshold. Non thermal effects of US include increased cell membrane permeability, increased intracellular calcium, increased rate of protein synthesis by fibroblasts, production of stronger collagen fibers, altered enzymatic activity, accelerated angiogenesis, increased macrophage responsiveness, accelerated bone healing, increased release of inflammatory mediators…, and decreased
length of the inflammatory stage of tissue healing.”

97036

**HUBBARD TANK**

*Thermal or hypo-thermal effect
*Relaxation
*Spasm
*Increased mobility (exercise)

97039

**UNLISTED MODALITY**

*Must be specific as to type and time
*Specific documentation required

**THERAPEUTIC PROCEDURES**

*(THESE ARE TIMED CODES, IN 15 MINUTE UNITS)*

97110

**THERAPEUTIC PROCEDURE**

**EXERCISE**

*To develop strength, endurance, range of motion, and flexibility

**THERAPEUTIC PROCEDURE**

The patient has progressed to a point in his/her treatment whereby it is now indicated that the clinician or therapist will assist in developing strength, endurance, range of motion, and flexibility. This may be accomplished by use of supervised exercises such as a treadmill for endurance, weights and/or resistance training for strength, isokinetic exercise for range of motion and stretching exercises for flexibility.

**NOTE:** **WHEN USING THIS CODE, BE SPECIFIC WITH THE EXPLANATION OF WHAT INSTRUCTIONS HAVE BEEN GIVEN TO THE PATIENT. ALSO NOTE THAT THE TECHNIQUE HAS BEEN**
EXPLAINED, DEMONSTRATED, AND PERFORMED SATISFACTORILY BY THE PATIENT. IT WOULD ALSO BE PRUDENT TO EXPLAIN WHY THESE EXERCISES SHOULD BE PERFORMED UNDER SUPERVISION RATHER THAN AT HOME.

97112

NEUROMUSCULAR RE-EDUCATION

*Re-education of movement, balance, coordination, kinesthetic sense, posture and proprioception.

NEUROMUSCULAR RE-EDUCATION

Due to the patient’s condition, it is necessary to assist in effecting a change to improve function. This will be done by use of Proprioceptive Neuromuscular Facilitation (PNF) technique. This technique is designed to assist with movement, balance, coordination, etc.

NOTE: WHEN USING A TERM SUCH AS PROPRIOCEPTIVE NEUROMUSCULAR FACILITATION (PNF), IT WOULD BE APPROPRIATE TO DEFINE THE TERM. IT SHOULD ALSO BE NOTED THAT THERE ARE OTHER TECHNIQUES WHICH WOULD FIT INTO THIS CLASSIFICATION. DUE TO THE NATURE OF THIS PARTICULAR THERAPEUTIC PROCEDURE, THE CLINICIAN SHOULD IDENTIFY WHY NMR IS REASONABLE AND NECESSARY.

97113

AQUATIC THERAPY WITH THERAPEUTIC EXERCISES

*Exercise in a non weight bearing position (i.e. pool therapy)

97116

GAIT TRAINING
(INCLUDES STAIR CLIMBING)

*Post injury mobilization
GAIT TRAINING

Due to the nature of this patient’s illness/injury, it is now necessary to begin training in ambulation. This will include the three phases of gait (stance phase, swing phase, and support phase).

*NOTE: It would be most important with this procedure, to identify what the nature of the problem is, and why this would be beneficial to the patient. You might also indicate that the patient should continue therapy at home, with assistance.*

97124

MASSAGE

*Includes effleurage, petrissage, and/or tapotement (stroking, compression, percussion)*

MASSAGE

It appears that this patient requires massage therapy to help reduce muscle spasm and stiffness. Due to the nature of this patient’s condition, manual kneading, pressure and friction are necessary.

*NOTE: It would be advantageous to the clinician, the massage therapist, and the patient to identify the area(s) to be treated, the length of time for treatment, and when a re-evaluation should be performed.*

97139

UNLISTED THERAPEUTIC PROCEDURE

*Specify by report*

*NOTE: WHEN USING THIS CODE, THE MEDICAL NECESSITY AND EXPLANATION OF PROCEDURES MUST BE COMPREHENSIVE.*
97140

**MANUAL THERAPY TECHNIQUES**

*Mobilization/manipulation, manual Lymphatic drainage, manual traction to one or more regions, each 15 minutes

**MANUAL THERAPY TECHNIQUES**

Due to the nature of this patient’s condition it is necessary to utilize joint mobilization, myofascial technique, and/or manual traction to help reduce pain and or muscle spasm, increase joint range of motion, reduce inflammation or soft tissue swelling, etc.

**NOTE:** “MANUAL THERAPY TECHNIQUES CONSIST OF, BUT ARE NOT LIMITED TO, CONNECTIVE TISSUE MASSAGE, JOINT MOBILIZATION AND MANIPULATION, MANUAL TRACTION, PASSIVE RANGE OF MOTION, SOFT TISSUE MOBILIZATION AND MANIPULATION, AND THERAPEUTIC MASSAGE. TYPICALLY, THE GOALS OF MANUAL THERAPY ARE TO MODULATE PAIN, INCREASE JOINT RANGE OF MOTION, AND REDUCE OR ELIMINATE SOFT TISSUE SWELLING, INFLAMMATION OR RESTRICTION. THESE TECHNIQUES ALSO INDUCE RELAXATION AND IMPROVE CONTRACTILE TISSUE EXTENSIBILITY.”

**NOTE:** THIS PROCEDURE MAY NOT BE PERFORMED IN AN AREA WHERE A CMT CODE HAS BEEN UTILIZED. THIS MUST BE NOTED AND EXPLAINED IN ANY REPORT, OR IN THE DAILY NOTES. IT MAY BE BENEFICIAL TO BE SPECIFIC WHEN IDENTIFYING THE ANATOMICAL LOCATION OF EACH AREA OF TREATMENT.

97150

**GROUP THERAPY**

*This is reported for each member of the group
*Two or more participants constitutes a group
**97530**  
*Therapeutic Activities*  
*Increase functional performance*

**Therapeutic Activities**

At this point in the patient’s care it is indicated that we assist him/her in the performance of their regular activities. We instruct the patient in proper lifting procedures, transfer procedures (sitting to standing, lying to sitting, etc.) in an effort to help increase their functional performance.

**Note:** When using this code, be specific with the explanation of what instructions have been given to the patient. Also note that the technique has been explained, demonstrated, and performed satisfactorily by the patient. Also identify why this procedure should be performed under direct supervision rather than at home.

**97535**  
*Self-Care/Home Management*

*Training  
*Compensatory training  
*Safety procedures  
*Instruction in the use of adaptive equipment.  
*Specifically for instruction in ADL’s (Activities of Daily Living)*

**Note:** When using this code, be specific with the explanation of what instructions have been given to the patient. Also, note that the technique has been explained, demonstrated, and performed satisfactorily by the patient. Choose carefully, and document which patients are going to receive these procedures. Generally, these procedures are not prescribed to patients with relatively simple problems (low grade strains and sprains).
NOTE: IN ORDER TO DESCRIBE THE TYPE OF CARE THAT IS BEING PROVIDED FOR THE PATIENT, AND TO DIFFERENTIATE BETWEEN WORK HARDENING AND WORK CONDITIONING, THE FOLLOWING MAY BE USEFUL WHEN COMMUNICATING WITH A THIRD PARTY PAYER.

WORK CONDITIONING: A physical restorative program which is work relevant, intensive, and goal oriented. The goal in work conditioning is to help the patient regain their pre-injury health status so that they may return to work. The overall focus of work conditioning is the physical restoration of health as it relates to function.

WORK HARDENING: The general purpose of work hardening is to help the patient tolerate the requirements of their occupation. This type of program incorporates a highly structured and specific program. The requirements of the program usually include work specific tasks and goals. The patient is being prepared to return to a specific job task that is within their physical abilities. The overall focus of work hardening is the physical restoration of health as it relates to job specific tasks.

It is most important, when considering an order for these procedures, to provide specific documentation as to the medical necessity relating to the physical state of the patient and the requirements of the occupation. It might also be beneficial to identify the provider’s training or expertise in this area.

SPECIAL NOTES:

- When reporting and billing for Vertebral Axial Decompression, CPT code 97012 (Mechanical Traction) is the most appropriate code. Another code that is appropriate is the HCPCS code S9090, Vertebral Axial Decompression. (It would be wise to check with the third party payer to determine which code is acceptable, and if it is reimbursable).
• When reporting and billing for the **hydro-bed, aqua-bed, dry hydro-bed, etc.**, the use of CPT code 97039 (unlisted modality) would be the most appropriate code. It would also be appropriate to supply supporting documentation to establish the medical necessity for these modalities. It should be noted that this type of care is **NOT** whirlpool therapy (97022). The provider might point out, in the notes, the benefits and physiologic effects of the constituent parts of this form of therapy. (heat, percussion, pressure, whirlpool action without submersion.

The following is a sample of a note that may be used for dry hydrotherapy.

**BASED ON SUBJECTIVE COMPLAINTS, WHICH WERE CONFIRMED BY EXAMINATION FINDINGS, IT WOULD APPEAR THAT THIS PATIENT WOULD BENEFIT FROM A COURSE OF PHYSICAL THERAPY, REHABILITATION, AND SPECIFIC SPINAL ADJUSTMENTS. AT THIS POINT IN THE PATIENT'S CARE, IT WOULD APPEAR THAT THE USE OF A DRY HYDROTHERAPY BED IS INDICATED. THE RATIONALE FOR THIS MODALITY IS AS FOLLOWS.**

1. **THE MODALITY UTILIZES THE EFFECTS OF SOFT TISSUE MUSCLE KNEEDING AND MOIST HEAT.**
2. **THE EFFECT ON THE PATIENT IS MUSCLE RELAXATION, INCREASED VASODILATION, AND THE REDUCTION OF PAIN.**
3. **IT WILL ALSO PREPARE THE PATIENT FOR THE SPINAL ADJUSTMENT SO THAT THE BENEFIT OF THE ADJUSTMENT WILL BE BETTER RECEIVED BY THE PATIENT.**
4. **OVERALL, THE INCORPORATION OF THIS MODALITY WILL, IN ALL LIKELIHOOD, REDUCE THE AMOUNT OF TIME NECESSARY TO BRING THE PATIENT TO A POINT OF MAXIMUM MEDICAL IMPROVEMENT**

When reporting and billing for **cold laser**, CPT code 97039 (unlisted modality) would be the most appropriate code. It would also be appropriate to supply supporting documentation to establish the medical necessity for this modality. It should be noted that there is a HCPCS code for low level laser (S8948).
Kinesiology Taping:

It would appear that the use of CPT strapping codes 29200-29280 and 29520-29590 are not supported, except for the initial service, or when restorative treatment is provided, or when the service is not intended to be a stabilizing effect, but rather a therapeutic one. Generally, after the initial service, kinesiology taping is considered to be part of other services such as 97112 (neuromuscular re-education, therapeutic procedures, etc.). It would be appropriate to report a supply code (A4450 or A4452) for the tape being used.

Finally, it is most important to remember that when using timed codes, 15 minutes, means 15 minutes. If more than 15 minutes is spent with a patient, the number of 15 minute units should be reported. If using less than 15 minutes, a -52 modifier should be applied to the appropriate CPT code. Also, when using 97140 with a CMT code, on the same date of service, a -59 modifier is used with the 97140 code.

Once again, there are ethical, legal, and procedural elements in prescribing and performing any form of physical medicine. Remember, the medical necessity MUST be established in writing, and documented into the patient medical record.

MISCELLANEOUS CODES

(JUST SOME FRIENDLY ADVICE, WHEN USING THESE CODES, IT MIGHT BE BENEFICIAL TO INCLUDE THE PROVIDERS CREDENTIALS RELATING TO THE SERVICES PROVIDED)

97750

*Physical performance test or measurement (e.g. leg, musculoskeletal, functional capacity), with a written report, each 15 minutes.

97760

*Orthotic(s) management and training (including assessment and fitting
when not otherwise reported.), upper extremity(s) lower extremity(s) and/or trunk, each 15 minutes.

Whether you use the CPT codes or not, whether you are reimbursed by a third party payer or not, whether you are reimbursed by the patient or not, medical necessity is absolutely necessary for anything you do for, or to, the patient.

GENERAL INFORMATION WHICH MAY BE HELPFUL WHEN IMPLEMENTING EVIDENCE BASED DOCUMENTATION RELATING TO REHABILITATION

1. “Muscles control the movement of body segments around joints and provide stability by resisting the movement of joint surfaces through joint approximation.”

2. “Muscle contraction is controlled by input from motor nerves. Each motor nerve innervates a number of muscle fibers. One motor nerve and all of the muscle fibers that it innervates are known as a motor unit.”

3. A muscle strain is “to over exercise; to use to an extreme and harmful degree, 2 excessive effort or undue exercise. 3. an overstretching or overexertion of some part of the musculature…”

4. “It is recommended that the targeted tissues be heated between 104 degrees (40C) to 113 degrees (45C) for 5-10 minutes to increase their extensibility.”

5. “Exercise and physical activity can increase muscle strength and endurance, retard bone loss, control joint swelling and pain, improve joint
lubrication, reduce joint stiffness, maintain or improve flexibility, increase aerobic fitness and reduce fatigue, reduce postural sway, prevent exacerbations and risk factors associated with a sedentary lifestyle, and promote weight management in patients with localized inflammation”.15

6. “Orthotics including braces, taping, and splints, are recommended for patients with localized inflammation to limit the load imposed on the affected structures. This can help the individual return to activity sooner and limit exacerbations of inflammation and local tissue damage.”16

7. “Pulsed US is recommended in the acute stage of rehabilitation for patients with localized inflammation because its mechanical nonthermal may help stimulate and accelerate the inflammatory phase, leading to earlier resolution, and help relieve pain.”18

8. “Exercise and physical activity can increase muscle strength and endurance, retard bone loss, control joint swelling and pain, improve joint lubrication, reduce joint stiffness and reduce fatigue…in patients with localized inflammation.”21

9. “Spinal nerve roots are particularly susceptible to injury because they do not have dense connective tissue between their fibers and because the connective tissue covering the nerve, the perineurium, may be missing or not well developed.”23

10. “It is a commonly held belief that LBP almost always resolves within 4-6 weeks. However, there is evidence to suggest that this is not the case.”24

REFERENCES
1,5,8,9,10,16, 17,18, 19,20,21,22,23 Cameron, Michelle, Monroe, Linda, “Physical Rehabilitation, Evidence-Based Examination, Evaluation, and Intervention, Saunders, 2007,
As an exercise, please review the following case history and examination findings. The information contained in this case history will be used in the quiz which will be administered at the end of this program.

The key to reviewing this case history is to identify the parts which are used to determine appropriate codes that conform to ethical guidelines.

A 28 year old male enters the office reporting that he was involved in a sports related accident that occurred yesterday. He said that while playing tennis, he was trying to serve when he felt a sharp pain in his low back, right shoulder and the right side of his neck. He said that the pain in the neck went to the thumb and index finger on the right hand. He also said that the low back pain went from the lower back, on the right side, to the back of the thigh, to the level of the knee, on the same side. He reported that the right shoulder caused pain when he raised his arm. He demonstrated raising his arm in front of him and to the side. He said that the pain started at about 45 degrees, in both directions. He reported no other problems.

The patient reported that immediately after the incident he went home and applied ice. He said that he felt a little better, but when he awoke this morning, the pain increased. He reported that his problems continue to be getting worse despite the application of ice.

He said that prior to this incident he as never had any other problems, but, his father and older brother have had similar problems. He said that they both received chiropractic care which seemed to help them.

The patient reported that he has not taken any medication. He denies any surgical history. He denied any history of heart, lung, bowel, or urinary problems. He is employed as an insurance investigator for Big Bear Insurance Company. He said that he has not missed any time from work.

The examination findings are as follows:

- Vitals were all within normal limits (height, weight, blood pressure, pulse rate and respirations).
- Palpation revealed mild spasm to be present in the left SCM. Mild spasm was also present in the Trapezius musculature, on the right.
- The lumbosacral paraspinal musculature, on the right is in mild to moderate spasm.
- Heel and toe walking were intact.
- Minor’s sign was mildly painful, on the right side with no specific radiation.
- Finger to nose test was negative.
- The patient was able to stand on each leg independently with active tendon movement.
- Range of motion studies, using a hand held inclinometer, which were performed actively, revealed the following information:

**Cervical Spine**

<table>
<thead>
<tr>
<th>Motion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexion</td>
<td>Complete with moderate pain toward the extreme.</td>
</tr>
<tr>
<td>Extension</td>
<td>Complete with mild pain toward the extreme.</td>
</tr>
<tr>
<td>R. Lat. Flex.</td>
<td>Complete with slight pulling on the left.</td>
</tr>
<tr>
<td>L. Lat. Flex.</td>
<td>Limited to 10 degrees with moderate to severe pain.</td>
</tr>
<tr>
<td>R. Rotation</td>
<td>Limited to 15 degrees with moderate to severe pain.</td>
</tr>
<tr>
<td>L. Rotation</td>
<td>Limited to 10 degrees with moderate to severe pain.</td>
</tr>
</tbody>
</table>

**Thoracic Spine**

No Complaints

**Lumbar Spine**

<table>
<thead>
<tr>
<th>Motion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexion</td>
<td>Complete with moderate pain on the right. Some radiation of pain into the right leg, to the level of the knee.</td>
</tr>
<tr>
<td>Extension</td>
<td>Complete with mild, right sided low back pain.</td>
</tr>
<tr>
<td>R. Lat. Flex.</td>
<td>Complete with a pulling on the right, with some pain into the right buttock.</td>
</tr>
<tr>
<td>L. Lat. Flex.</td>
<td>Complete with a pulling on the right side with some pain into the right buttock.</td>
</tr>
<tr>
<td>R. Rotation</td>
<td>Complete with mild pain on the right.</td>
</tr>
</tbody>
</table>
L. Rotation Complete with mild pain on the right.

Shoulders
Flexion Limited to 90 degrees with moderate pain.
Extension Complete with mild discomfort.
Abduction Limited to 90 degrees with moderate pain.
Adduction No complaints
Int. Rotation Complete with some pain at the extremes.
Ext. Rotation Complete with some pain at the extremes.

NOTE: All areas of complaints were limited to the right side.

Elbows, wrists, and finger ranges of motion revealed no apparent abnormalities or areas of complaint.

Hips, knees, ankles, and toes revealed no apparent abnormalities or areas of complaint.

- Libman’s test revealed a moderate pain threshold.
- Mankopf’s sign was negative for pain magnification.
- Cervical Compression test was negative.
- Maximum Cervical Rotation Compression test was negative for radicular pain, but cause localized right sided neck pain.
- Cervical Distraction test was positive for localized, right sided neck pain.
- Apprehension test produced some pain in the right shoulder.
- Codman’s test produced some discomfort in the right shoulder.
- Allen’s test was negative.
- Adson’s test was negative.
- Tinel’s sign was negative.
- Patrick’s test was negative.
- Straight Leg Raising test, performed in the seated position, produced some localized pain, on the right.
- Double leg raising test produced moderate localized pain, on the right,
with a complaint of discomfort into the hamstring, on the right.
- Kemp’s test was negative for radicular pain, but caused some low back pain on the right, with a pulling sensation into the right buttock.
- Lasegue’s test was negative, but produced some localized pain in the right low back, and a pulling sensation into the right buttock.
- Braggard’s test was negative.
- Deep tendon reflexes which included the Biceps, Triceps, Brachioradialis, Patella, and Achilles, were 2+ bilaterally.
- Pathologic reflexes were absent.
- Cranial nerves appeared to be within normal limits.
- Dermatome distribution testing, via a pinwheel, were all within normal limits.
- The patient is right handed and dynamometer test revealed a right hand dominance.
- Romberg sign was negative.

Remember, each of the requirements for appropriate CPT codes are based on audit requirements. It is important to note that the requirements are specific, and are directed to specific codes.

When working with CPT codes, the appropriate choice of an E/M code is not based on reimbursement, but rather on what the history, examination, and medical decision making leads you to. With that thought in mind, the choice of an appropriate and ethical physical therapy code is based on the needs of the patient, not the equipment in your office. Remember, offices are patient driven, not procedure driven.

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