Assessment Visit Documentation

By
Dr. Ron Short, DC, MCS-P, CPC, CPCO

MIPS Letter

- By now you should all have received a letter from CMS regarding MIPS.
- This letter simply tells you whether you should participate in MIPS or not.
- About 90% of chiropractors will be exempt from MIPS.

Medicare Reviews

- The results are starting to come in from the Strategic Health Solutions reviews.
- It has taken about 5 months for the reviews to be completed.
- Most are coming back as failed.
- Many are also resulting in extrapolations.
- If you receive bad results from one of these reviews get help in fighting them.

Assessment Visit/Treatment Visit

- One of the ways that chiropractic is different from conventional medicine is that we have two distinct types of patient encounters or patient visits.
- The Assessment Visit
    - The Assessment visit is when we assess the patient's condition and develop a treatment plan.
    - Assessment visits occur at the initial visit to establish the baseline condition of the patient and every 30 days thereafter to monitor the change in the patient's condition.
- The Treatment Visit
    - Treatment visits occur between Assessment visits.
    - Treatment visits are where we implement the treatment plan developed during the Assessment visit.
    - The documentation burden is different for the Assessment visit than it is for the Treatment visit.

Initial Visit Documentation

- There are two major purposes for the initial visit documentation;
    - 1. Capture the basic demographic and medical history information of the patient, and
    - 2. Establish the baseline condition of the patient
- The baseline condition will be used to establish the progress of the patient and the medical necessity of the care rendered.
- Initial Visit Required Documentation
    - History

You can reach Dr. Short at 217-285-2300 or at chiromedicare@gmail.com. Dr. Short's website is www.chiromedicare.net.

© 2017 The Schad Group, LP

  - Description of the present illness
  - Evaluation of musculoskeletal/nervous system through physical examination
  - Diagnosis
  - Treatment plan
  - Date of initial treatment
- It is important to remember that, as far as Medicare is concerned, you are only justified in examining and treating the area or areas of complaint.
- This is why it is important to determine all areas of complaint before starting treatment.

History

- The history recorded in the patient record should include the following:
  - Symptoms causing patient to seek treatment;
  - Family history if relevant;
  - Past health history (general health, prior illness, injuries or hospitalizations; medications; surgical history);
  - Mechanism of trauma;
  - Quality and character of symptoms/problem;
  - Onset, duration, intensity, frequency, location and radiation of symptoms;
  - Aggravating or relieving factors; and
  - Prior interventions, treatments, medications, secondary complaints.
  - Social History (not required but advisable)

Description of the Present Illness

- The next required element is a Description of the Present Illness.
- The required elements are;
  - Mechanism of trauma;
  - Quality and character of symptoms/problem;
  - Onset, duration, intensity, frequency, location, and radiation of symptoms;
  - Aggravating or relieving factors
  - Prior interventions, treatments, medications, secondary complaints; and
  - Symptoms causing patient to seek treatment.
- This is a repeat of many of the elements from the History.
- The only logical reason that they would repeat required information is that they want the doctor to directly review this information with the patient.

____
____
____
____
____
____

© 2017 The Schad Group, LP

Evaluation of musculoskeletal/nervous system through physical examination

- The next element is Evaluation of musculoskeletal/ nervous system through physical examination.
- This will include;
    - Orthopedic Tests
    - Neurological Tests
    - Range of Motion Testing
    - Muscle Strength Testing
    - Palpation
    - Outcome Assessments
- Some are teaching that we no longer need ortho-neuro tests now that P.A.R.T. is available.
- This is not the case.
- Orthopedic and neurological testing is used to rule out pathological processes and is part of the standard of care within the profession.
- Palpation will give you the elements of P.A.R.T. which you will need to prove the presence of a subluxation.
- Medicare regulations state in the Medicare Benefits Policy Manual, Chapter 15, Section 240.1.3: "The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam,"
- Outcomes assessment questionnaires should be used at the initial assessment to determine functional impairment and at the re-exam to prove functional improvement.
- The two most commonly used are the Revised Oswestry Low Back Pain Disability Questionnaire (ROLBPDQ) and the Neck Disability Index (NDI)
- For the ROLBPDQ:
    - A significant problem is anything that scores above 11%.
    - Significant improvement is indicated by a 30% improvement between adjacent questionnaires 30 day apart.
    - The questionnaires should be administered every 30 days.
    - MMI is indicated when a patient scores below 11%.
- For the NDI:
    - A significant problem is anything that scores above 10%.
    - Significant improvement is indicated by a 30% improvement between adjacent questionnaires 30 day apart.
    - The questionnaires should be administered every 30 days.
    - MMI is indicated when a patient scores below 10%.

Diagnosis

- Diagnosis is the next required element.
- The diagnosis information that applies to you is different for each jurisdiction.
- There is information regarding diagnosis in your Local Coverage Determination.

____

____

____

____

____

____

© 2017 The Schad Group, LP

Treatment Plan

- The next required element is the Treatment Plan.
- Medicare requires three items in a treatment plan.
  - Recommended level of care (duration and frequency of visits);
  - Specific treatment goals;
  - Objective measures to evaluate treatment effectiveness.

Specific Treatment Goals

- The specific treatment goals should include both short-term and long-term goals.
  - The short-term goal would be to get the patient past their current level of disability.
  - The long-term goal would be to get the patient to the level of no disability.
- Sometimes you reach the long-term goal and sometimes you don't.
- Note it in the chart either way.
- For example: a patient chooses "I cannot stand for more than ½ hour without increasing pain"
- Based on the example above, an example of an appropriate short-term treatment goal would be:
  - To enable the patient to stand for more than ½ hour without increasing the pain by re-exam
- An example of appropriate long-term Treatment goal would be:
  - To enable the patient to stand for as long as they want without pain.
- This process is repeated at each re-exam noting the changes in the responses to the outcome assessment questionnaires.
- The frequency and duration should be changed at each re-exam to reflect the changes in the patient's condition.

Re-Exam

- The assessment visit is not limited to the initial visit.
- You should re-assess the patient's condition every 30 days to determine if they are making significant progress and if further care is indicated.
- It is important that this be done on a regular basis because it indicates to third-party payers that you are monitoring the patients' condition and are responsive to changes in their condition.
- The re-exam should include:
  - A history update.
  - An exam including a retest of all positive and significant negative orthopedic and neurological tests.
  - The re-administration of the outcome assessment questionnaire(s).
  - A new treatment plan.
  - Changes in diagnoses if indicated.

Summary

- Medicare has specific documentation requirements for the initial assessment visit.
- Meeting these requirements will give you the baseline information needed prove medical necessity.

____

____

____

____

____

____

© 2017 The Schad Group, LP