Treatment Plans: The Roadmap to Patient Care

I had some requests to include the corrections from last week's seminar. Here they are:

Corrections from Last Week

- The presenter stated that Option 2 on the ABN is only for non-covered services.
- Option 2 also applies to covered services.
- From the ABN Booklet issued April 2011
- "Health care providers/suppliers will not violate mandatory claims submission rules under Section 1848 of the Social Security Act when a claim is not submitted to Medicare at the beneficiary's written request when selecting this option." The presenter stated: "Do not submit a claim with Box 14 over 60 days old."
- This left the impression that you should either change the date every 60 days or not file the claim.
- Both are wrong.
- You are required to file the claim and you cannot change the date unless there is a new condition or a recurrence.
- The presenter used "exacerbation" incorrectly.
- "An exacerbation is a temporary, marked deterioration of the patient's condition because of an acute flare-up of the condition being treated."
- Taken from LCD for Arizona.
- The presenter used Degenerative Joint Disease diagnosis as example for unpaid claim.
- No carrier or MAC accepts that diagnosis.
- Stated that diagnosis needed to be sprain/strain to be paid by Medicare.
- Diagnosis needs to come from LCD to be paid by Medicare.
- The presenter stated that a Medicare claim would be denied if it only had a subluxation diagnosis and a secondary diagnosis.
- The following is from the Illinois LCD, but virtually all LCDs contain similar language.
- "The level of the subluxation must be specified on the claim and must be listed as the primary diagnosis. The neuromusculoskeletal condition necessitating the treatment must be listed as the secondary diagnosis."
- The presenter stated that Item 19 on the CMS 1500 form needed to contain the date of x-ray or the word PART.
- Item 19 usage is designated by the individual carrier or MAC.
- Item 19 hasn't been universally used for the date of x-ray since 2000.
- He also stated that leaving box 19 blank will result in non-payment of claim. This is not true.
- He stated that all x-rays over 1 year old are virtually useless as far as Medicare is concerned.
- Medicare Benefits Policy Manual, Chapter 15, Section 240.1.2:"In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted provided the beneficiary's health record indicates the condition has existed longer than 12

months and there is a reasonable basis for concluding that the condition is permanent."

- The presenter stated that you must prove subluxation via x-ray.
- He also stated that P.A.R.T. was only to be used if the x-ray was over a year old, otherwise it has no use.
- Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2:"A subluxation may be demonstrated by an x-ray or by physical examination, as described below."
- The presenter stated that only an "affidavit" was official documentation for Medicare purposes.
- The Medicare Benefits Policy Manual, Chapter 15, Section 240.1.2 (A) and (B) list the Medicare documentation requirements for chiropractors.
- Nowhere in those sections is an affidavit mentioned.
- The presenter discussed the Office Compliance Program.
- He stated that it was required this year.
- The final rules have not yet been published and the deadline has not yet been set.
- He oversimplified the process of developing an Office Compliance Program.
- He promoted a book that he had written for a do-it-yourself compliance program.
- The OIG does not have a model compliance program to offer because of the complexities of the program and the high degree of customization required.
- In a conversation with an OIG representative during the HEAT Provider Compliance training, I was told that do-it-yourself manuals are not considered effective Office Compliance Programs.
- The presenter stated that the chiropractic adjustment is always a covered service.
- The chiropractic adjustment is a covered service as long as functional improvement is expected.
- Once the patient reaches MMI, the adjustment is no longer covered.
- The presenter used the term "aggravation" to describe a change in the condition.
- The term aggravation is not defined or used in the Medicare manuals.
- The presenter stated that an exacerbation was only worth 1 to 6 visits.
- This is not correct in light of the way that he was using the term exacerbation.
- He also did not know that the deadline for changing your participation status was extended to February 14.
- When evaluating information presented by a Medicare expert, be very careful to note the source of the material.
- If the expert does not reference the Medicare manuals, consider the information to be suspect.

Treatment Plan

- Treatment plans are required by Medicare.
- They are also sound medical procedure.
- They provide both you and the patient a roadmap of care.Almost all chiropractors produce a treatment plan.
- It is usually called a report of findings and usually only goes to the patient.

- We just do a terrible job of of reporting the treatment plan to Medicare and the insurance companies.
- The following is from the 2009 OIG report.

Quoted from the May 2009 OIG Report:

- "Documentation for treatment plans was insufficient"
- "The medical reviewers indicated that treatment plans are an important element in determining whether the chiropractic treatment was active/ corrective in achieving specified goals."
- "The goal may change throughout the treatment episode, but it should be documented in the medical record to demonstrate active/corrective treatment."
- "Of the 76 percent of records that reviewers indicated contained some form of treatment plan, 43 percent lacked treatment goals, 17 percent lacked objective measures, and 15 percent lacked the recommended level of care."

Medicare requires the following elements in a treatment plan:

- Recommended level of care (duration and frequency of visits)
- Specific treatment goals
- Objective measures to evaluate treatment effectiveness

In other words:

- How long and how often are you going to see the patient
- What are you trying to accomplish
- How do you know when you have accomplished it

Recommended Level of Care

- Duration and frequency of care
    - 3 times per week for 4 weeks
- Set a date for the re-exam
    - If the patient doesn't make that date, note why in the patient's record

Specific Treatment Goals

- Just saying "to reduce pain" or "to increase range of motion" is not acceptable. These are general, non-specific goals
- Specific goals should be derived from the outcome assessment questionnaires
- An example would be:
    - If the patient states on the outcome assessment questionnaire "I cannot stand for longer than ½ hour without increasing pain."
    - Your treatment goal should be "To have the patient able to stand for longer than ½ hour without increasing pain by the re-exam."
- 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.

Objective Measures to Evaluate Treatment Effectiveness

- This happens automatically with the use of the outcome assessment questionnaire at the re-exam.
- When used properly it demonstrates improvement toward short-term goals and long-term goals.
- The progress should be noted in the patient's chart.

Use of the outcome assessment questionnaire in the treatment plan

- The outcome assessment questionnaire should be administered:
    - During the initial examination
    - Two weeks into the treatment plan
    - During the re-examination

Administer the outcome assessment questionnaire at two weeks into the treatment plan to determine if progress is being made.

From Mercy Conference Guidelines:
"**Acute Disorders**: After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered."[1]

If improvement is documented, continue care, document that patient is progressing in daily notes, and continue on the treatment plan
If no improvement is documented, change the treatment parameters (different therapy, different adjusting technique, etc.), document that the treatment was changed and why in the daily notes and continue on the treatment plan.

An outcome assessment questionnaire is considered "current" if it is less than 30 days old.

Date of Initial Treatment

- The date of initial treatment is in Box 14 of the CMS 1500 form.
- The date of initial treatment is the date that treatment started for this condition.
- This is either the date of the accident or the date that the patient first felt symptoms.
- If the patient cannot clearly define when they first felt pain then this is the date that you first adjusted the patient
- Do not put down a new initial treatment date unless there is a new condition or a recurrence of the current condition. To do so could be considered fraudulent.

[1] Guidelines for Chiropractic Quality Assurance and Practice Parameters, Page 124

- A good rule of thumb is: If you conduct a new initial exam and/or administer a new ABN, you have a new initial treatment date.

If you have any questions or if you want information regarding the Office Compliance Program contact me at 217-285-2300 or at chiromedicare@gmail.com.

Dr. Ron Short, DC, MCS-P
Heartland Consulting Group
217-285-2300
ChiroMedicare@gmail.com
www.chiromedicare.net