Dynamic Chiropractic

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How to Retain More of Your Medicare Money, Part 2

THE TREATMENT PLAN

Ronald Short, DC, MCS-P

The next step in keeping the money Medicare pays you is documenting medical necessity. The key element that Medicare is looking for regarding medical necessity is the treatment plan. The May 2009 OIG report stated that the treatment plan was an area of deficiency. Twenty four percent of the records didn't even contain a treatment plan. Of those that did, 43 percent lacked treatment goals, 17 percent lacked objective measures and 15 percent lacked the recommended level of care.

For a treatment plan to meet Medicare's requirement, it should have three elements: recommended level of care (duration and frequency of visits); specific treatment goals; and 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; and how do you know when you have accomplished it? These are all reasonable questions that, if answered properly, will give a Medicare reviewer all the information they need to determine that care is medically necessary.

Recommended Level of Care

The recommended level of care is the duration and frequency of visits. This is sometimes dictated by specific requirements of specialized techniques or the clinical experience of the doctor. Let's see what Medicare has to say about this:

"The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxation (e.g., sprains or strains) problems may require as many as three months of treatment, but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained. Chronic spinal joint condition implies, of course, that the condition has existed for a longer period of time and that, in all probability, the involved joints have already 'set' and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency."[1]

Medicare recognizes that an uncomplicated acute case may require three months of treatment and a chronic case may require longer. It also recognizes that the early stages of treatment may be more frequent than the later stages. The somewhat standard three times per week for four weeks and then re-examine would fit within their parameters.

Specific Treatment Goals

This is where the outcome assessment questionnaires are utilized. Medicare wants specific treatment goals it can evaluate to determine if progress is occurring. Goals such as "reduce pain" or "increase range of motion" are not specific enough to satisfy Medicare. For care to be medically necessary: "The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered

must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function."[2]

The utilization of outcome assessment questionnaires will give the doctor a baseline indicator of the patient's functional ability in an objective format. This information is then used to develop the treatment goals and later assess improvement of function. When the patient shows no improvement of function, active care ends and maintenance care begins.

To establish the specific treatment goals that Medicare requires, use the outcome assessment questionnaire(s) for the area(s) of complaint to establish a baseline level of function for the patient at the time of the initial visit. For each section where a deficiency is indicated, move up one to two levels and set that as your goal to accomplish by the re-exam.

Objective Measures to Evaluate Treatment Effectiveness

The outcome assessment questionnaires provide the ideal objective measure for improvement of function. Medicare reviewers can easily see if the patient is improving. There is no limit on the number of visits that a patient can have, but rather the number of visits is limited by the medical necessity of the patient. As long as the outcome assessment questionnaires continue to demonstrate improvement of function, Medicare considers the care medically necessary.

While not a Medicare requirement, it is advisable to re-administer the outcome assessment questionnaires after two weeks of care to determine that the patient is progressing. This is a standard of care and is found in the *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."[3]

The whole process will follow this pattern. During the initial visit, administer outcome assessment questionnaires to establish the baseline functional ability of the patient and develop the treatment plan accordingly. Two weeks into care, re-administer the outcome assessment questionnaires to determine the patient's progress. If the patient is progressing, continue care. If the patient is not progressing, change what you are doing. Re-administer the outcome assessment questionnaires at the re-exam and note the patient's progress. If the patient is progressing, develop a new treatment plan and continue care. If the patient is not progressing, refer the patient appropriately.

The proper use of the treatment plan cannot be overemphasized. Medicare reviewers are looking for this document in the records it requests. Without a viable treatment plan, the care that you rendered will be considered medically unnecessary and you will be required to refund the money you have been paid.

Date of Initial Treatment

The date of initial treatment is a critical piece of information for a Medicare reviewer. Without it, they cannot properly identify when a new episode begins. Naturally, a new episode begins on the day a patient first presents at your office. After the patient has reached the point at which there is no further functional improvement, active care is completed. If the patient returns for care after the condition has been quiescent for 30 or more days, you have a recurrence and a new episode begins. The surest way to survive a review is to prove that the care rendered was medically necessary. The treatment plan and the outcome assessment questionnaires are the primary tools to accomplish this.

References

1. *Medicare Benefit Policy Manual*, Chapter 15, Section 240.1.5.
2. *Medicare Benefit Policy Manual*, Chapter 15, Section 240.1.3.
3. Haldeman S, et al. *Guidelines for Chiropractic Quality Assurance and Practice Parameters.*

Part 1 of this article appeared in the Jan. 29 issue. This is the second of five articles discussing Medicare claims and strategies for ensuring full reimbursement.

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