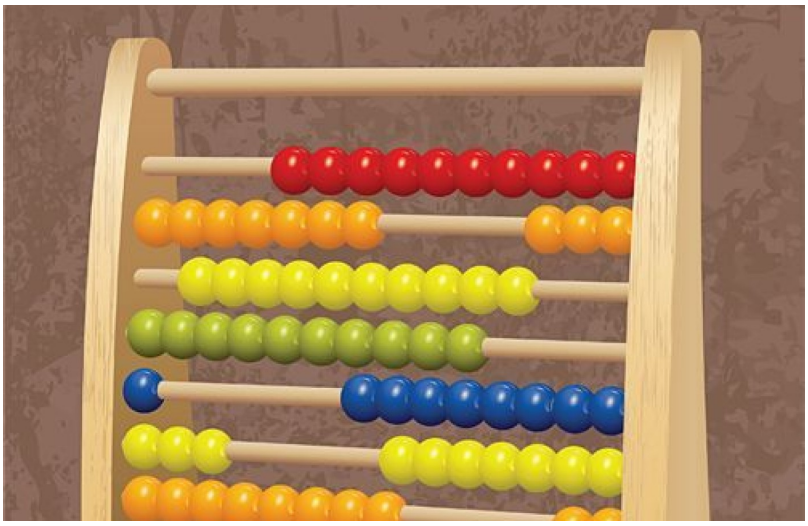
Dynamic Chiropractic



MARKETING / OFFICE / STAFF

# Are Your Practice Protocols Up to Date?

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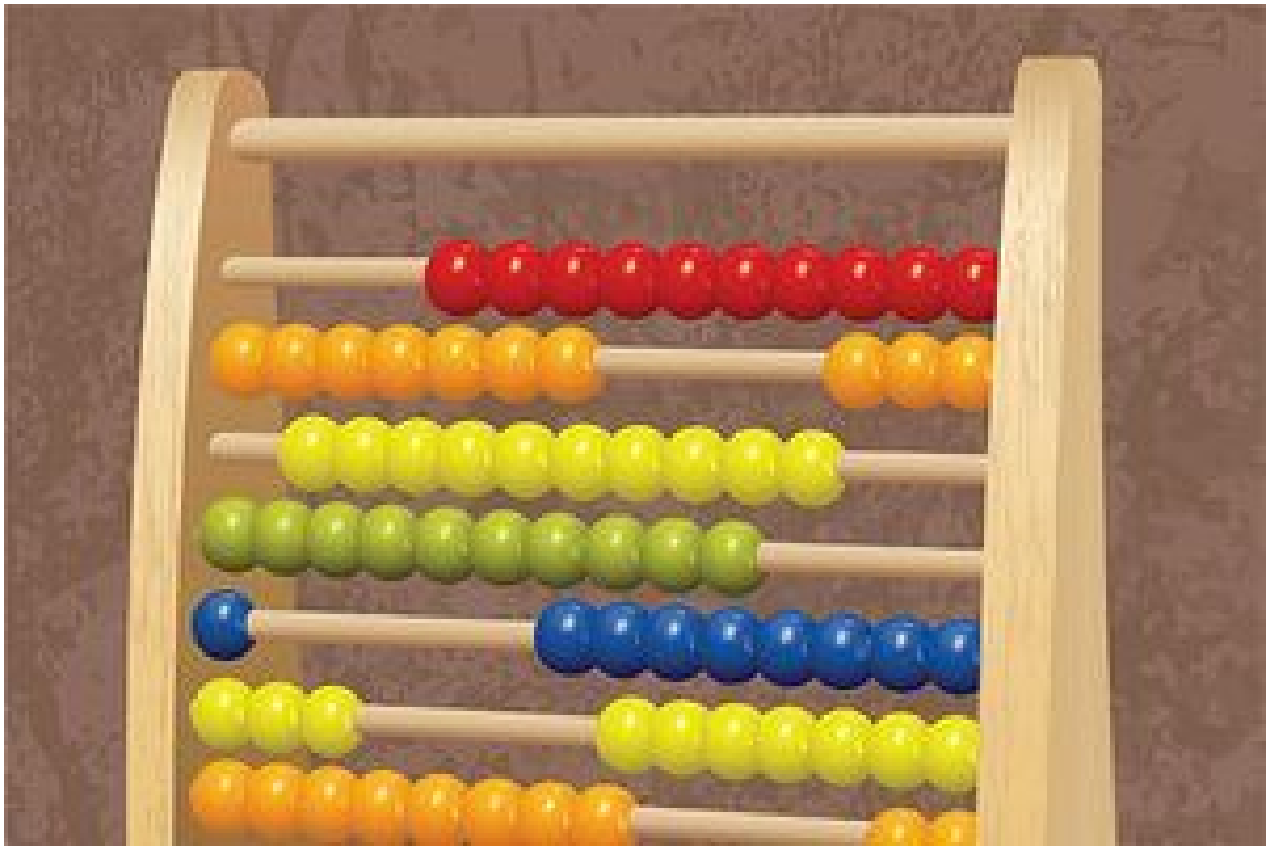
Are you continuously updating your capabilities in an effort to provide medically necessary treatment and rehabilitation services? If you want to get paid, it would be very wise to do so NOW.

Case Management

How are you managing cases? When we buy something online, we can track it and always know where it is. Well, that's how your patient case management should work. Does it?

A good patient case management policy will have a significant impact on your bottom line. When you do an online order, the package proceeds from point A to point B, and it is all choreographed to get your package to you via the best route in the shortest amount of time.



That is the perfect blueprint for a good patient case management program. Implement a program where you can plot, and track your patient's progress (outcomes) throughout their entire treatment plan.

Here are the categories in a patient case management plan. Problem Focused Exam – Imaging (if necessary) – Diagnostic Testing – Treatment Plan (Acute care protocols, Rehabilitation protocols, Progress exams, Follow-up diagnostic testing to establish outcomes and the need for continued care, ADLs, Exacerbations, Update diagnosis as patient improves, etc.

All this information can fit nicely on a one page form, and it should be the first page in every patient file. It will be a constant reminder as to what your patient needs, and when the need it. So, when a patient needs a re-exam or follow-up diagnostic testing, etc., have the patient tell the front desk to schedule the procedure on their next visit (or notify the front desk yourself). Remember, technology rules progress, and the public is addicted to technology.

Technology

Sadly, I see providers spending tens of thousands dollars on the "wrong stuff," equipment that does not enhance their ability to document medical necessity and does not provide access to extended medically necessary treatment, and most critically, is often results in cases being ineligible for reimbursement because the trendy software and hardware does not result in the documentation of medical necessity or positive outcomes.

There are many advanced coding and documentation options available to chiropractors that are compliant with the chiropractic scope of practice, but we have allowed outside entities to mislead us into using the limited and confining CMT codes. The CMT codes require the documentation of nine components for each region. Think about that for a moment and review your CMT documentation to see how many components you have actually documented.

I am a subcontractor to a national law firm as an expert in coding and documentation. They hire me to review the insurance company's audits of the DC's coding and billing practices. The CMT codes factor into every insurance audit. And in a recent audit, the insurance company is demanding the return of $137,000 for "overpayment" of the CMT codes due to the lack of adequate subjective and objective documentation.

Here is just one example of a coding option: Most chiropractors use Trigger Point Therapy as part of their treatment protocols. And most don't even bill for it. But when they do, they bill procedure code 97140 Manual Therapy Techniques. THIS IS WRONG and it will raise the audit flag.

As a Provider Compliance Consultant, I represent chiropractors who are or who have been audited. And I can tell you that 90% of audits are based the following: CMT code 97140 and the lack of diagnostic testing that documents medical necessity with objective findings of functional impairment and positive outcomes.

Now, here's what is wrong with using Trigger Point Therapy as a treatment procedure. First of all, Trigger Point Therapy *is a technique, not a treatment procedure represented by a billable CPT code*. The appropriate procedure representing the Trigger Point Therapy technique is "Ischemic Compression," which should be billed as Massage 97124 (effleurage, petrissage, tapotement, stroking, compression, percussion).

The following is critical: When performing the 97124 massage procedure on the same day as a CMT procedure, the 97124 massage procedure must be performed on a separate region than the CMT procedure, and the -59 modifier must be used to identify the massage procedure is being performed on a separate region, and should be billed as 97124-59 massage (compression). And your documentation should specifically name the muscle(s) being treated.

CAUTIONARY NOTE: If the muscle(s) being treated attach to the region where the CMT was performed, they are considered as part of the CMT region and the massage procedure cannot be billed separately.

[pb]Compliance

Implementing a thorough compliance program for your practice is vital.

Specifically, a compliance program which you and your staff can refer to on your computers for clarification, is essential. We've all heard this one before, "If it isn't written down, it didn't happen." Well, this too has changed as a result of advanced technology. In the past, most documentation was merely opinion based subjective information. Basically, it was an educated guess. Today, this would read: "If objective findings of functional impairment and positive outcomes of improvement as a result of objective diagnostic testing are not documented in the patient record, it didn't happen."

Remember, results from diagnostic testing, objective findings and positive outcomes are the requirements for documenting medical necessity. They are the first steps to accessing authorization for treatment and reimbursement.

The first visit should include the typical evaluation and management services of the history and examination of the chief complaint, etc. The second visit is when the diagnostic testing is performed. If diagnostic testing is performed on the first visit, the insurance will consider the testing as a component of the evaluation and management service and they will not pay for the diagnostic separately.

Here's what is happening now regarding the importance of compliance. Here in Pennsylvania, Blue Cross Blue Shield (Highmark) has hired a Third Party Administrator (TPA) to manage all of the BC/BS claims for Chiropractic, Physical Therapy and Physical Medicine. If you don't have this in your state now, you will soon. The Third Party Administrator immediately reduced the number of chiropractic and physical medicine visits per year from twenty to eight. Obviously, this was not well received.

But, the reality is that nothing had really changed. Originally, there were twenty visits per year. I call "gift visits." Blue Cross Blue Shield will give the provider twenty "post-payment review" visits per year. Meaning, they will give you twenty visits per year without the provider having to submit the documentation for medical necessity in advance of treatment, i.e. "gift visits."

However, if the patient requires treatment beyond the initial twenty visits, the provider must submit the objective results from diagnostic testing that documents significant objective deficits and functional impairment that establishes the need for continued treatment, i.e. medical necessity. And, the insurance company has the right, at any time, to request the documentation of medical necessity for the first twenty visits for post-payment review.

If the provider cannot submit the required documentation from diagnostic testing to establish medical necessity, a post-payment review audit is likely, which usually results in the return of tens of thousands of dollars for "overpayment" made to the provider. So, the only difference is the "gift visits" have been reduced to eight. And, the documentation of medical necessity for the

authorization of additional visits begins with visit number nine. Actually, the eight visit limit significantly reduces the providers liability if it is determined that treatment is not warranted.

Here's the problem. The professional associations are fighting the implementation of this policy. They will lose. Like it or not, the insurance companies have every right to expect and demand the documentation of medical necessity based on diagnostic testing. No other provider group gets "gift visits."

Here's the solution. Rather than fighting the implementation of a reasonable policy, why not ask the question, "What diagnostic testing is acceptable, so we can remain in compliance with your diagnostic requirements?" It's that simple! Comply with the documentation requirements of the insurance reimbursement policy and develop a treatment plan that provides improved outcomes. The end result is a "win-win." Your patient improves as a result of the diagnostic testing, and you get paid.

Update your practice to include diagnostic testing that will comply with insurance documentation requirements and reimbursement policy. Add to your practice, compliance training and a patient case management program, and you will have a practice "makeover" that will stimulate growth and provide access to additional medically necessary treatment for your patients.