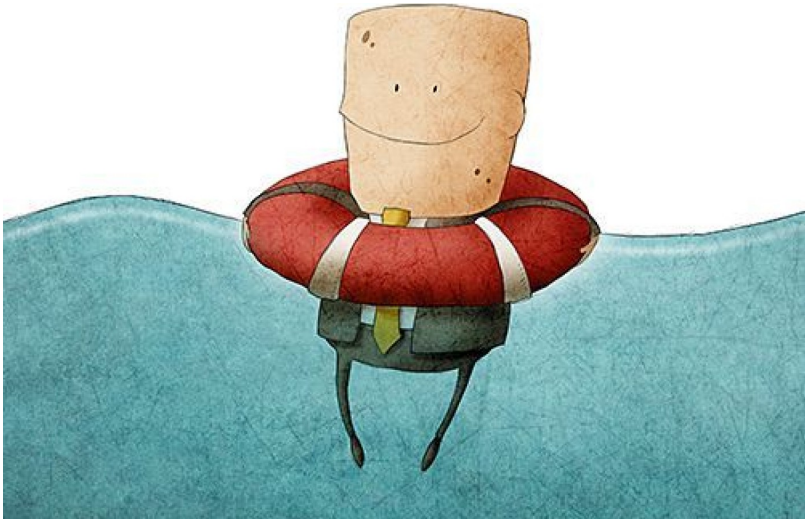
Dynamic Chiropractic



CHIROPRACTIC (GENERAL)

Documentation Made Easy: Demonstrate Medical Necessity

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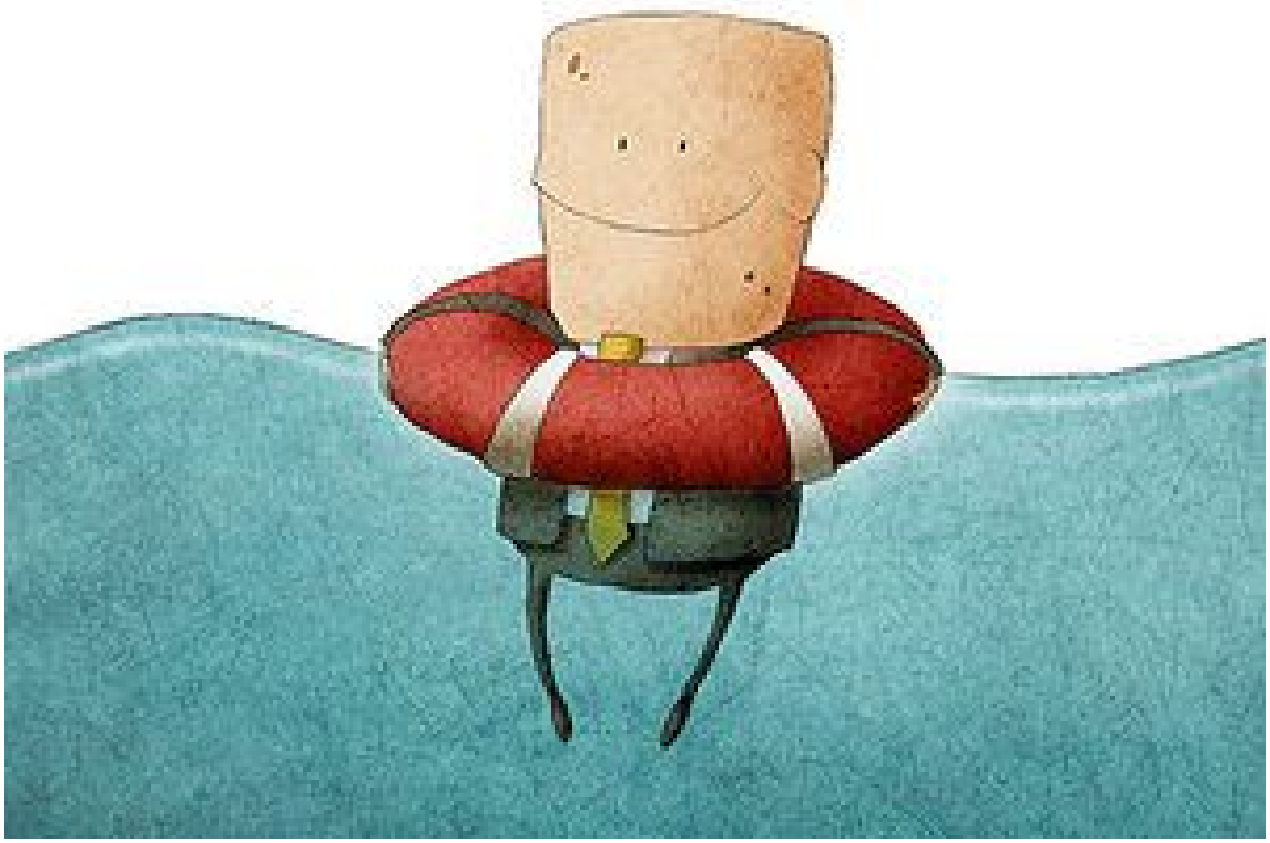
The insurance companies claim post-payment review audits are random. They are not! They are initiated by "red flags" raised by incomplete documentation, or inaccurate coding and billing patterns. Eventually, everyone will get audited.

Failure to have the required documentation will result in the return of all monies the insurance company has paid you (as overpayments) during the entire review period, which can be as long as five years. The overpayments made by the insurance companies are usually in the tens to hundreds of thousands of dollars. If you don't pay it back or make payment arrangements with interest, the insurance company can and will withhold your future reimbursements to offset the overpayments.

Real-estate values depend on location, location, location. Your practice protection depends on documentation, documentation, documentation. Proper documentation of significant objective deficits and positive outcomes will ensure reimbursement and will protect your practice against post-payment review audits.

Documentation 101



Question: Do you agree with the following statement? "The reason the insurance companies are denying your claims is because they have determined that your services were not medically necessary." I have asked this question to hundreds of DCs since 1994 and the answer is always *yes*.

Question: Can you define medical necessity? Again, I have asked this question to hundreds of DCs since 1994, and the answer is always *no*. Chiropractors are not getting paid because they don't know the definition of medical necessity. Documenting medical necessity is required if you want your services to be eligible for insurance reimbursement.

To document medical necessity, the provider must submit evidence of significant objective deficits that identify functional impairment through accepted objective diagnostic testing methods compatible with the current AMA's *Guides for the Evaluation of Permanent Impairment.*

Once you implement diagnostic testing methods into your practice, you will get paid. The number-one reason an insurance company can deny your claims is the lack of documentation supporting medical necessity. You should build or rebuild your practice on the clinically accepted foundation of objective diagnostic testing. In every state, insurance companies must pay for all medically necessary services. All you need to do to be eligible for reimbursement is provide the proper documentation of the significant objective deficits that reveal functional impairment, i.e., medical necessity.

the window describing (documenting) all of the specifications and features, would you? Well, that's what the insurance companies are expecting from us: objective test results that document functional impairment and the need for chiropractic treatment and/or rehabilitation.

Medical Necessity

A provider must document the need for a particular item or service for the diagnosis and treatment of disease, injury or defect. A provider must also document in the patient record, active

symptomatology and evidence of disease, injury or defect. Evidence = significant objective deficits from clinical testing that reveal functional impairment. In addition, there must be the expectation of improvement. You must provide the documentation of positive outcomes (progress) and you must know the insurance company's reimbursement guidelines.

An example: The following applies to most insurance reimbursement guidelines. "Chiropractic services are medically necessary when the member (patient) has a neuromusculoskeletal disorder, the medical necessity for treatment is clearly documented and improvement in the condition is documented within the first two weeks of chiropractic care. When no improvement is documented within the first two weeks, additional chiropractic care is considered not medically necessary unless the chiropractic care has been modified. If the chiropractic treatment has been modified, improvement in the condition should be documented within 30 days."

So, if you document medical necessity with significant objective deficits, and you document improvement in the condition within two weeks, you will get paid for all medically services until your patient reaches maximum medical improvement (MMI) or pre-injury status. If no improvement in the condition is documented within the first two weeks, you must modify the chiropractic treatment as needed and report the improvement within 30 days.

Proper documentation of medical necessity and positive outcomes will provide you with access to all of the treatment necessary to return your patient to MMI or pre-injury status. And the insurance companies will pay you for those services. Yes, it requires a little change in your diagnostic and documentation procedures, but the reward is well worth it: eliminating those costly denied claims. Enhanced Coding, Documentation and Compliance (ECDC) options that are compliant with insurance reimbursement policy are available and will provide growth and greater protection to your practice.

About Critical CMT Codes

The CMT codes (98940-98943) include extensive documentation requirements that are time consuming and very difficult to document without diagnostic testing. The following information, taken from the ACA's *Clinical Documentation Manual, 2nd Edition,* describes the nine components associated with documenting the CMT codes. The times shown represent the time requirements for the appropriate level of Evaluation and Management (E&M) service included in each level of CMT.

Three pre-service components include: documentation and chart review, imaging review, test interpretation and care planning. Three intra-service components include: pre-manipulation and palpation procedures, manipulation procedures and post-manipulation assessment procedures. Three post-service components include: chart documentation, consultation and reporting. Here are the relevant codes:

- 98940 – 12 minutes total time, plus the nine components
- 98941 – 17 minutes total time, plus the nine components
- 98942 – 21 minutes total time, plus the nine components
- 98943 – 14 minutes total time, plus the nine components

Caution: Yes, the CMT codes can be used as audit traps. If you use the CMT codes and you are subject to an insurance post-payment review audit, you must have the required documentation – all of it – including the time (number of minutes) the service was provided / performed.