

Billing for Same-Day Visits and Medicare Documentation

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Q: What would be the proper way to bill for a patient who is seen twice in one day, during which he received a chiropractic manipulation on both visits, but electrical stimulation only on the first visit?

A: When billing for a second service on the same day, the procedure or service that was repeated will be coded a second time, but with the modifier -76. This modifier is used to indicate that a procedure or service was repeated subsequent to the original service. Therefore, you would bill one CMT service without any modifier, and a second CMT with the modifier -76 (98940-76). The billing for electrical stimulation (97014) would not require any modifier. While this type of repeated service may be useful, it's not typical and might be prone to nonpayment. Therefore, a sound medical rationale is needed and should be done in as concise and objective a manner as possible, in the form of a short letter or report included with the billing.

Medicare Documentation Requirements

Due to the many questions I have received on Medicare documentation, I am providing the Medicare (CMS) requirements for chart-note documentation below. When documenting care, always have in mind that Medicare (or any insurance carrier, for that matter) is looking for objective and functional changes as a result of care.

On Initial Visit

A. History: History should include: 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 and secondary complaints.

B. Description of the present illness, including: 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 and secondary complaints; and symptoms causing patient to seek treatment. (Note: Symptoms should bear a direct relationship to the level of subluxation.)

C. Evaluation of musculoskeletal/nervous system through physical examination.

D. Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms might refer either to the condition of the spinal joint involved, or to the direction of position assumed by the particular bone named.

E. *Treatment plan*: The treatment plan should include the following:

- recommended level of care (duration as well as frequency of visits);
- specific treatment goals;
- objective measures to evaluate treatment effectiveness.

F. *Date of the initial treatment*.

On Subsequent Visits

The following documentation requirements apply whether the subluxation is demonstrated by X-ray or by physical examination.

A. *History*:

- review of chief complaint;
- changes since last visit;
- system review (if relevant).

B. *Physical examination*:

- exam of area of spine involved in diagnosis;
- assessment of change in patient condition since last visit;
- evaluation of treatment effectiveness.

C. *Documentation of the treatment provided on day of office visit*.

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