Documenting Physical Medicine:
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Good Documentation Tells a Story

Tell Us What You’re Thinking

- Why are the tests being ordered?
- Why did you decide to do what you did?
- What’s between your ears must appear in the documentation
- X-rays, labs, other diagnostic tests, referrals, and DME

Your Medical Records Must Tell the Story

- MN per 3rd Party Carriers
  - If you want them to pay the bill, you have to follow their rules
  - All are based in CMS’s guidelines
  - Additional requirements specific to each
Out of Network MN

Out of network is MN defined by:

- State scope of practice
- Peer review standards

A chiropractor who’s scope does not allow delegation of massage would not meet medically necessity guidelines because they are practicing outside of their scope.

If 99.9% of chiropractors would say that CMT over the phone is not medically necessary...

Weak Foundation = Weak Documentation

History = Both Input and Output

- Inputs:
  - Patient written history or update
  - OATs
  - Additional concerns in ROS
  - Pain Questionnaires
  - Written info into CT Intake
  - Online forms

- Outputs:
  - Doctor’s consultation notes
  - Expansion of written information
  - Deep digging beyond what the patient wrote and reported
  - Expand upon OATs to identify functional deficits
Proper History Sets Tone

• Ask probing questions to explore all conditions that might benefit from modalities and active rehab
• Make sure to clearly document during your consultation and history intake all details
• Begin with the end in mind

Your Exam = Doctor Finding

• Must be driven by history
• Include tests and measurements to quantify history
• Distinguish between important nuances
• Record everything in the patient’s record
• Determine whether additional diagnostic testing rationale exists

Sample Record Keeping Requirements

2. Examination:
   a. Vital signs as clinically indicated.
   b. Document examinations or tests ordered or performed and the results of each as necessitated by the patient's clinical presentation consistent with common healthcare practices.
   c. Document examinations of neuromusculoskeletal conditions using a format of inspection, palpation, neurological testing, range of motion, and orthopaedic testing.
   d. Document prognosis and/or outcome expectations.
   e. When clinically indicated, treatment options/alternatives should be documented.
   f. When referring to another healthcare provider, correspondence may be provided for patient care coordination.

Physical Signs of Instability

• Step deformity on standing, which reduces on lying
• Transverse band of muscle spasm, which reduces when lying
• Localized muscle witching while shifting weight from one leg to the other
• Shaking when bending forward
• Passive intervertebral motion testing suggests excessive mobility in the sagittal plane

Exam Findings

• Proper regional exam can elicit findings
• Muscle work? Discuss muscle tone and spasm (hyper/hypotonicity)
• Document weakness, wasting, upper/lower crossed syndromes

Postural Distortions
Postural Distortions

Proof Through Proper Diagnosis

- Know which diagnosis codes support medical necessity for massage/manual therapy, active care rehab and exercise
- Check with your insurance carriers for further clarification
- Make sure your diagnosis code justifies WHY the service was needed and why it is the BEST choice for treatment

Include DX that Necessitate Modalities and Procedures

- For EMS?
- For Ultrasound?
- For Application of Ice?
- For Laser?
- For Therapeutic Exercise?
- For Neuromuscular Re-Education?

Modalities & Rehab

My review found that your records did not contain a specific treatment plan or measurable objective improvement. A specific treatment should contain goals that can be measured in order to determine if treatment is effective. Goals can be set at 30-day intervals with regular evaluations to determine progress. Your records simply state goals such as reduce pain and improve range of motion. Without a measurable goal, even the slightest reduction in pain or improvement in range of motion, would mean that you met your goals. Treatment goals should be geared toward functional activities. If there is no functional defect and little pain, there is no clinical rationale for continued treatment.

If a passive therapy is provided, you must document the clinical rationale for that therapy, where the therapy was applied, and a time component. If active procedures are provided, you must document the clinical rationale for the service. For specific services (e.g., the exercises), note goals for those procedures, and include a time component. If the patient continues to present with the same or similar complaints, it may be that treatment has not been effective in providing relief. We can expect to see results within 3-5 visits for any given therapy. If no measurable objective improvement is seen within this time frame, the therapy should be discontinued and other treatment options should be considered. If goals are not achieved within 30 days, the record must clearly document why the goals were not achieved. A referral may be indicated at that time.

Dig Deeper

- Muscle Spasm because of what?
- What might muscle spasm cause?
  - Torticollis
  - Stiffness
  - Radicular Syndrome
- Weak muscles need to be strengthened
- Tight muscles need to be stretched

728.2 Became....
**Written Plan of Care**

- Should be sufficient to determine the medical necessity of treatment, including:
  - The diagnosis along with the date of onset or exacerbation of the disorder/diagnosis;
  - A reasonable estimate of when the goals will be reached;
  - Long-term and short-term goals that are specific, quantitative and objective;
  - The frequency and duration of treatment; and
  - The specific treatment techniques and/or exercises to be used in treatment.

**Medicare’s Plan of Care**

The plan of care, at a minimum, should contain:

- Diagnoses;
- Long-term treatment goals;
- Type of rehabilitation therapy services (physical therapy, occupational therapy, or speech-language pathology) – identifies each specific intervention, procedure or modality, in order to support billing and verify correct coding;
- Amount of therapy – number of treatment sessions in a day;
- Duration of therapy – number of weeks or number of treatment sessions; and
- Frequency of therapy – number of treatment sessions in a week.

**Clinical Rationale**

- The treatment plan must include rationale for all treatment
- Able to justify the “why”
- Necessary for each service provided with 3rd party payers
- Allows reader to understand what the doctor is thinking
- As though answering the patient’s question, “Why are you prescribing X?”

**Basic Treatment Plan:**
Todd’s treatment plan for this episode begins on 11/15/2016 and is projected to be completed by 1/15/2016.

- **Chief Complaint:** pain and stiffness in the back of the neck
- **Primary Treatment:** Dryneedle and Activation Chiropractic Manipulative Therapy (CMT) (appox. 10 to 24 visits) to the cervical spinal region at a frequency and duration of 3 visits per week for next 4 weeks followed by a re-evaluation within 30 days to determine the necessity of ongoing treatment.
- **Supportive Therapy:** To optimize the treatment effectiveness, the following supportive therapy is ordered:
  - **Ultrasound (20min):** ultrasound with contact medium to be applied to the bilateral tibial bone in the cervical and left trapezius, shoulder regions for 3-4 minutes per region to address limited joint motion and decrease pain by 50%
  - **During the relief phase of treatment: Initial frequency and duration 1/2 to 2 per week for next 2 weeks:
- **Treatment Plan:** Short Term: Ability to sit at the computer for up to 4 hours without pain within 30 days; Long Term: Ability to sit at the computer for a full 8 hour work day without pain by 1/15/16.
- **Advised:**
  - **Home/Self Care:** Todd was instructed in home care recommendations that included the use of a home cold pack, which was issued today. He was instructed to use ice for 20 minutes to reduce pain and discomfort and to repeat after 60 minutes. He was further instructed to discontinue the use of ice after 3 hours. He was also directed to perform light neck stretches as demonstrated in today’s visit with the following frequency: 3 sets of 10 reps, 3 times per day to tolerance
  - **Next Visit:** Patient achieved continue with treatment plan as scheduled

**Use Caution When Prescribing**

- Outcomes like relaxation, stress relief, or better physical conditioning to run a marathon are CA not MN
- You must have an active TX Plan with specific deficits and goals
- Treatment must be aimed at improving function

**Treatment Plan is the Sum of Its Parts**

- A comprehensive treatment plan helps to prove medical necessity
- The treatment plan can answer questions before they are asked
- It’s far more than 3 X 4
- It validates your “doctor thinking” and gives you a roadmap to follow
A Fact Sheet to Refer To

General Documentation Requirements

• Daily notes are not all different from straight CMT
• The note must reflect all the care provided
• Help the reader understand WHY each service was performed and how it helped

Establish Medical Necessity

• Diagnosis for each area you want to treat
• Functional goal for each activity and area of treatment
• Diagnosis codes linked to the treatment with the goal so you know when you’re complete
• Treatment plan includes all the services you want to perform
• Fill your “bag of tricks” and pull as needed

Daily Visit Note Requirements

The “Rules”

There are three general levels of Physical Medicine and Rehabilitation modalities and procedures, and each has its own rules and guidelines:

• **Supervised Modalities (90700-90702):** are generally called “per encounter codes.” This means that although it’s important to document the treatment time for each, the billing for each code is not time-dependent. Each service is billed one time per patient encounter. For example, if the patient received Electric Muscle Stimulation, billed as 90701, for 10 minutes on the upper thoracic musculature, and for another 10 minutes on the lumbar paraspinal musculature, the services is billed only once for that patient encounter, regardless of time spent.
• **Unsupervised Modalities (90710-90716):** are modalities that require one on-one attendance and are billed in 15-minute increments. The total time spent for each procedure is documented and billed. Proper billing for each 15-minute unit of service will be clarified further below.
• **Therapeutic Activities (91130-91136):** are services that require one-on-one attendance and are billed in 15-minute increments. The total time spent for each procedure is documented and billed. Proper billing for each 15-minute unit of service will be clarified further below.

Medicare’s PT Requirements

• Evaluation and Plan of Care (may be one or two documents). Include the initial evaluation and any re-evaluations relevant to the episode being reviewed.
• Certification (physician/NP approval of the plan) and recertifications when records are required after the certification/recertification is due. See definitions in section 220 and certification policy in section 220.1.3 of this chapter. Certification and recertification of the plan when applicable are required for payment and must be submitted when records are requested after the certification or recertification is due.
• Progress Reports (including Discharge Notes, if applicable) when records are requested after the reports are due. (See definitions in section 220 and descriptions in 220.3 D).
• Treatment Notes for each treatment day (may also serve as Progress Reports when requested information is included in the notes), and
• A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands their reasoning for services that are more extensive than is typical for the condition treated. A separate statement is not required if the record justifies treatment without further explanation.
PT Services: Per Aetna

• Treatment consists of a prescribed program to relieve symptoms, improve function and prevent further disability for individuals disabled by chronic or acute disease or injury
• Treatment may include various forms of heat and cold, electrical stimulation, therapeutic exercises, ambulation training and training in functional activities
• Medically necessary services must be restorative or for the purpose of designing and teaching a maintenance program for the patient to carry out at home

PT Services: Per Aetna

• Must relate to a written treatment plan and be of a level of complexity that requires the judgment, knowledge and skills of provider to perform and/or supervise the services
• The amount, frequency and duration of the services must be reasonable, the services must be considered appropriate and needed for the treatment of the disabling condition and must not be palliative in nature

Supervised Modalities

• 97010-97028 do not require one-on-one contact by the provider
• Billed only once per encounter
• Are not time based for billing purposes
• Daily documentation should include the time spent on the modality

Use of Ice-Cold Therapy

• Causes vasoconstriction (shrinkage of blood vessels), decreasing blood flow to an area, and slowing the body’s metabolism and its demand for oxygen.
• The therapeutic goals include reducing edema, easing inflammation, and blocking pain receptors.
• Cold application is more effective than heat for sprains or other soft tissue injuries and is the preferred treatment within the first 48 hours after injury.

Use of Heat

• Heat causes vasodilation increasing blood flow to a specific area.
• Increases the oxygen, nutrients, and various blood cells delivered to body tissues
• Relieve local pain, stiffness, or aching, particularly of muscles and joints
• Aids in removal of wastes from injured tissues, such as debris from phagocytosis

Mechanical Traction

• Manual or mechanical pull on extremities or spine to relieve spasm and pain
• Considered medically necessary for chronic back or neck pain
• Typically used in conjunction with therapeutic procedures, not as an isolated treatment
• Standard treatment is to provide supervised mechanical traction up to 4 sessions per week
• For cervical radiculopathy, treatment beyond 1 month can usually be accomplished by self-administered mechanical traction in the home.
Interferential Therapy (IFT)

- A treatment modality that is proposed to relieve musculoskeletal pain and increase healing in soft tissue injuries and bone fractures.
- Two medium-frequency, pulsed currents are delivered via electrodes placed on the skin over the targeted area producing a low-frequency current.
- IFT delivers a crisscross current resulting in deeper muscle penetration.
- Theorized that IFT prompts the body to secrete endorphins and other natural painkillers and stimulates parasympathetic nerve fibers to increase blood flow and reduce edema.

Constant Attendance Modalities

- 97032-97039 require direct one-on-one patient contact by provider.
- These are time-based codes for billing.
- Documentation should include total time spent.

One on One means “One on One”

- One-on-one attendance is defined as “maintaining visual, verbal, and/or manual contact with the patient during the provision of the service”. One-on-one attendance is achieved when the provider is attending to one patient individually for each minute counted toward the required minutes in order to bill the CPT code for that particular therapy service.

Ultrasound

- Benefits of ultrasound:
  - Speeding up of the healing process from the increase in blood flow in the treated area.
  - Pain decrease from the reduction of swelling and edema.
  - Gentle massage of muscles, tendons, and/or ligaments in the treated area because no strain is added and any scar tissue is softened.

Laser Therapy

- Low-level laser therapy is a non-invasive light-source treatment that has no heat, sound or vibration.
- By reducing the duration of inflammation as well as enhancing specific repair and healing process, laser therapy has been proven to provide pain relief, reduce damage due to the injury and loss of function.
- Indications for laser therapy to promote healing:
  - Inflammation
  - Pain
  - Edema
  - Muscle strains
  - Ligament sprains
  - Nerve injuries/irritations

Therapeutic Procedures (97110-97546)

- Therapeutic Procedures are time-based codes for billing purposes.
- The patient is active in the encounter.
- Require direct one-on-one patient contact by provider of the service.
- Documentation should include the time spent and procedure performed.
Therapeutic Exercises-97110

- Instructing in and directly supervising the exercises
- Purpose to develop and/or maintain muscle strength and flexibility including range of motion, stretching and postural drainage
- Performed actively, active-assisted, or passively (e.g., treadmill, isokinetic exercise lumbar stabilization, stretching, strengthening)

Therapeutic Exercises-97110

- Ther EX considered medically necessary for loss or restriction of joint motion, strength, functional capacity or mobility which has resulted from disease or injury.
- Standard treatment is 12 to 18 visits within a 4- to 6-week period
- Exercising done subsequently without a physician or therapist present and supervising = not covered

Neuromuscular Reeducation-97112

- This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception to a person who has had muscle paralysis and is undergoing recovery or regeneration.
- Goal is to develop conscious control of individual muscles and awareness of position of extremities

Neuromuscular Reeducation-97112

- May be considered medically necessary for impairments which affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity) that may result from disease or injury such as severe trauma to nervous system, cerebral vascular accident and systemic neurological disease.
- Standard treatment is 12 to 18 visits within a 4- to 6-week period

Therapeutic Activities-97530

- This procedure involves using functional activities (e.g., bending, lifting, carrying, reaching, pushing, pulling, stooping, catching and overhead activities) to improve functional performance in a progressive manner
- The activities are usually directed at a loss or restriction of mobility, strength, balance or coordination
- Require the professional skills of a provider and are designed to address a specific functional need

Therapeutic Activities-97530

- May be appropriate after a patient has completed exercises focused on strengthening and range of motion but need to be progressed to more function-based activities
- Dynamic activities must be part of an active treatment plan and directed at a specific outcome
Muscle Therapies: 97124 & 97140

- Manual techniques that include applying fixed or movable pressure, holding and/or causing movement of or to the body, using primarily the hands.
- Affects the musculoskeletal, circulatory-lymphatic, nervous, and other systems of the body with the intent of improving a person’s well-being or health.
- Most widely used include Swedish massage, deep-tissue massage, sports massage, neuromuscular massage, and manual lymph drainage.

- Considered medically necessary as adjunctive treatment to another therapeutic procedure on the same day.
- Designed to restore muscle function, reduce edema, improve joint motion, or for relief of muscle spasm.
- Often not considered medically necessary for prolonged periods and should be limited to the initial or acute phase of an injury or illness (i.e., an initial 2-week period).

Myofascial Release

- Described as soft tissue mobilization through manipulation.
- Skilled manual techniques (active and/or passive) applied to soft tissue to effect changes in the soft tissues, articular structures, neural or vascular systems.
- Examples are facilitation of fluid exchange, restoration of movement in acutely edematous muscles, or stretching of shortened connective tissue.
- Considered medically necessary for treatment of restricted motion of soft tissues in involved extremities, neck, and trunk.

Augmented Soft Tissue Mobilization (ASTM)

- Augmented soft tissue mobilization a non-invasive mobilization technique.
- Treats chronic musculoskeletal disorders that result from scarring and fibrosis.
- Entails the use of hand-held tools made from bone or stone or metal and a lubricant on the skin to scrape and mobilize scar tissue.
- Promotes circulation, thus, promoting healing.
- However, there is insufficient evidence to support the effectiveness of ASTM – Per Aetna.

When To Use Muscle Therapies

- Patient can benefit from soft tissue work.
- Different from or in addition to CMT adjustment code.
- Consultation or Exam Findings.
- Difficult to administer CMT due to spasm, swelling, tenderness.

What Active Muscle Work Help?

- Many patients seek soft tissue treatment after losing flexibility or function due to an injury or accident.
- Helps with ongoing neck, back, shoulder, and hip conditions, or any other area containing soft tissue.
- Other conditions treated by myofascial release therapy include TMI disorder, carpal tunnel syndrome, fibromyalgia and migraines.
Reasonable and Appropriate

- Two times a week 15-30 minutes for 4-6 weeks then re-evaluate might be reasonable
- Three times per week for an hour going on 6-8 weeks is often not medically necessary

Patients Need This

- Patient symptoms that indicate a need for soft tissue work usually include:
  - Tightness of tissue that restricts motion or pulls the body out of alignment, causing patient to favor or overuse one hip or shoulder
  - A sense of excessive pressure on muscles or joints that produces pain
  - Pain in any part of the body, including headache or back pain

When To Use 97140

- To effect changes in soft tissues, articular structures, and neural or vascular systems
- To address a loss of joint motion, strength, or mobility
- Must be part of an active treatment plan directed at a specific outcome
- Daily routine visit documentation should include progress toward those stated goals

When to Use 97124

- Used to improve muscle function, stiffness, edema, muscle spasms or reduced joint motion
- When treatment is friction based, relaxation type massage that is less specific than 97140

Who Can Perform These Services

- Dependent upon State Law or Provider contract provision
- Should verify each patient’s plan to determine specific requirements
- Would be different guidelines if a cash service

Check PPO Contracts

- Provider contract can be more restrictive than State Law
- Example: Federal BCBS had specified that the physical therapy must be performed by a licensed physician
- Conclusion: Chiropractors cannot delegate services to a LMT...However....
Know the IRS Rules

• If must be doctor supervised, the LMT must be an employee
• Like when billing the service under doctor’s NPI
• Independent Contractor is NOT okay

Premera Provider News Flash
March 27, 2014

Federal Employee Plan (FEP) Retroactive Change to Massage Therapist Services

Effective Jan. 1, 2014, the Affordable Care Act mandated that insurers shall not discriminate against:
• Provider participation under the plan
• Coverage against any healthcare provider acting under the scope of the provider’s license
• Certification under applicable state law

Based on this change, FEP will no longer exclude services provided by massage therapists when billed and authorized by an MD, DO, DNP, or PA within the scope of their licensure.

This change is retroactive to Jan. 1, 2014. This change supersedes any June 2013 notification in which we notified contracted and non-contracted facilities that massage therapy services were covered for FEP members if ordered by a massage therapist.

If you have questions about this information, please call Physician and Provider Relations at 866-722-0714, option 4.
AMA/CPT Says “Each 15 Minutes”

Medicare’s “8-Minute Rule” Meets “15 Minute Rule”

- For time-based codes, you must provide direct treatment for at least eight minutes in order to receive reimbursement from Medicare.
- CMS and CPT have clarified that any timed based service, provided on its own, is not billable if performed for less than 8 minutes.

Timed Treatment Codes

- For a single timed code being billed in a visit:
  - Less than 8 min = 0
  - 8 up to 23 min = 1
  - 23 up to 38 min = 2
  - 38 up to 53 min = 3
  - 53 up to 68 min = 4
  - And so on.

- For multiple timed codes provided in the same session, add up the total minutes of skilled, one-on-one, time based therapy and divide that total by 15.
  - If eight or more minutes are left over, you can bill for one more unit.
  - If seven or fewer minutes remain, you cannot bill an additional unit.

Do the Math

Some HCPCS codes specify that direct (one-on-one) time spent in patient contact is 15 minutes. In those cases, the units are the appropriate number of 15-minute units of services. When only one service is provided in a day, a service performed for less than eight minutes should not be billed. When more than one unit of service is provided, the initial and subsequent services must total at least 15 minutes, and the last unit may be counted as a full unit of service if at least eight minutes of additional service has been furnished.

\[
8 + 7 = 15 \\
15 + 8 = 23 \rightarrow 2^{nd} \text{ Billable Unit}
\]

6 Minutes of Therapeutic Exercise

- Do not bill any CPT code.
- Threshold not met.
- Document the chart to include the exercise performed and note it was 6 minutes of time spent.
21 Minutes of Therapeutic Exercise

- Abdominal hollowing exercises = 12 minutes
- Cervical range of motion exercises = 9 minutes
- Total time = 21 minutes = 1 billable unit
- Note the chart with all services performed and time spent on each along with total time

28 Minutes of Therapeutic Exercise

- Lumbar Isometric Exercises = 13 minutes
- Lumbar stretching = 9 minutes
- Lumbar strengthening exercises = 6 minutes
- Total time = 28 minutes = 2 billable units
- Note the chart with all services performed and time spent on each along with total time

26 Minutes of NMR & 25 Minutes of Therapeutic Exercises

- 26 minutes of various proprioceptive strengthening exercises
- 13 minutes of lumbar stabilization exercises
- 12 minutes of lumbar stretching exercises
- Total time = 51 minutes = 3 billable units
- Documentation includes all services and time spent

51 divided by 15 = 3 with 6 left over
Did not make it to a fourth unit

10 Minutes of TherEx; 5 Minutes of Ultrasound and 5 Minutes of Manual Therapy

- 10 + 5 + 5 = 20 total minutes = 1 billable unit
- US and MT are each less than TE
- Bill where most time was spent
- Total time didn’t reach 23 minutes

Document Well

- Modalities and procedures add beautifully to chiropractic benefit
- Don’t let the lack of documentation trip you up
- Where much is given...much is required!