Ancillary Services: Yes, You Have to Document Those Too
Abbie Miller, MCS-P, CCCA

Why Is Documentation So Important?
• Ensure quality patient care
• Meet license requirements to protect the public
• Guard against malpractice actions
• Secure appropriate reimbursement
• Because...if it wasn’t written down, it didn’t happen!

Know your Audience
• Another health care provider
• Your State board
• A malpractice attorney
• Third party payer’s medical necessity auditor

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

FCA ANNOUNCEMENTS

Network: TND Events
Access Code: #Ego1gionalFCA

Attendance Desk Hours
Thursday 12:30pm – 7:00pm
Friday 7:00am – 9:00am, 11:00am – 12:00pm, 12:15pm – 2:00pm, 3:00pm – 5:00pm
Saturday 7:30am – 9:00am, 11:00am – 12:30pm, 12:45pm – 2:00pm, 3:00pm – 5:00pm

CLASS NOTES
Please pick up a lecture handout located in the back of the room. In order to retrieve an expanded version of our class notes, you will need the access code located at the end of your lecture handout. You WILL NOT be able to access the expanded version of these notes without this code.

If you are looking for diplomate hours, your badge must be stamped at the registration desk with a red ACM stamp. Your hours will be automatically credited with your required class size at the door to pertaining classes. Programs that mention or promote specific products, services, or companies are not eligible for approval to offer continuing education credits in the state of FL.

Today’s speaker has agreed to not mention specific products, services, or companies in this presentation. If this agreement is violated, please report to the FCA via the feedback form in your convention packet/show guide.

For the rules of the Florida Board of Chiropractic Medicine, please be sure to review our website for practice moves and times a day – “Standout desk” depending on which county you intend.
Good Documentation Tells a Story

Out of Network Medical Necessity
Out of network MN is defined by:
- State scope of practice
- Peer review standards

For Example:
A chiropractor whose scope does not allow delegation of massage would not meet medical necessity guidelines because they are practicing outside of their scope

Out Of Network Considerations
- Always patient’s responsibility for payment (even if you submit)
- Might be a managed care party to deal with even though no contract
- 3rd party may still request records and the like
ASHN’s Cover Sheet

- Extra Paperwork
- Need rationale to get payment
- Extra time spent by team members
- Still may not get paid by them
- If you are going to bill for OON, you still need to learn their systems.

Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

CMS SHOULD USE TARGETED TACTICS TO CURB QUESTIONABLE AND INAPPROPRIATE PAYMENTS FOR CHIROPRACTIC SERVICES

Under the Magnifying Glass

EXECUTIVE SUMMARY: CMS SHOULD USE TARGETED TACTICS TO CURB QUESTIONABLE AND INAPPROPRIATE PAYMENTS FOR CHIROPRACTIC SERVICES
OEI-01-14-00209

WHY WE DID THIS STUDY
Chiropractic services have the highest rate of improper payments among Fee-For-Service Medicare Part B services. (CMS Comprehensive Error Rate Testing program, Medicare covers chiropractic services to improve function, which it refers to as “active treatment,” but does not cover “maintenance therapy,” which is when further clinical improvement is not reasonably expected from ongoing treatment. Part B services are paid for on a reimbursement basis, and between 45 and 47 percent of all paid chiropractic claims were for maintenance therapy in 2012. Medicare fraud examiners alleged that submission and payment of Medicare services for beneficiaries receiving chiropractic services, such as physical therapy, may be improper."

You got a letter AND You got a letter AND You got a letter...

Strategic Health Audit Findings

Review Determination:
The claim for chiropractic services was paid in error. Adjustment or denial of the claim has been recommended to the Centers for Medicare & Medicaid Services (CMS).

Review Rationale:
The submitted initial visit documentation did not meet the required Medicare guidelines. The documentation did not note aggravating and/or relieving factors or prior interventions, treatments, and medications. (CMS Pub 100-2 Medicare Benefit Policy Manual, Chapter 15, § 240.1.2)

Review Determination:
The claim for chiropractic services was paid in error. Adjustment or denial of the claim has been recommended to the Centers for Medicare & Medicaid Services (CMS).

Review Rationale:
The submitted subsequent visit documentation did not meet the required Medicare guidelines. The documentation did not include the changes since the last visit or an assessment of change in the patient condition since last visit, and/or documentation of treatment effectiveness. (CMS Pub 100-2 Medicare Benefit Policy Manual, Chapter 15, § 240.1.2)

Review Determination:
The claim for chiropractic services was paid in error. Adjustment or denial of the claim has been recommended to the Centers for Medicare & Medicaid Services (CMS).

Review Rationale:
The submitted documentation did not support the diagnosis of subluxation, either through the presence of radiologic testing or physical examination of the thoracic region; therefore, did not support the treatment of the region. (CMS Pub 100-2 Medicare Benefit Policy Manual, Chapter 15, § 240.1.2, LCD L33609)
Strategic Health Audit Findings

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Review Rationale:
The submitted documentation did not meet the required Medicare guidelines. The documentation did not include notation of treatment effectiveness. (CMS Pub 100-2 Medicare Benefit Policy Manual, Chapter 15, § 240.1.2)

The Foundation of Your Foundation

• History is important
• Every time you begin a new episode of care (I, B, E)
• What the patient tells you isn’t enough
• Weak history = weak documentation of medical necessity

Weak Foundation = Weak Documentation

History = Both Input and Output

• Inputs:
  – Patient written history or update
  – OATs
  – Additional ROS concerns
  – 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
- Clearly document during 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 orthopedic 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.

Exam Findings

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

Physical Signs of Instability

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

Postural Distortions

- Distorted Plane
- Head Tilt
- Shoulders Unlevel
- Pelvis Unlevel
- Axis of Gravity
- Distorted Plane
Modalities & Rehab

My review found that your records did not contain a specific treatment plan or measurable objective improvement. A specific treatment plan with measurable, time-based goals is the foundation of proper treatment. Goals can be set at 30-day intervals in 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 deficit 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, list the specific services (e.g., the exercises, set goals for the 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 5-7 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.

Proof Through Proper Diagnosis

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

Coding

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

Include DX that Necessitate Modalities and Procedures

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

Written Plan of Care

Should be sufficient to determine the medical necessity of treatment, including:

- Dx along with Date of Onset or Exacerbation;
- Reasonable estimate of when goals will be reached;
- Long-term and short-term goals that are specific, quantitative and objective;
- Frequency and Duration of treatment; and
- 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

- Treatment plan must include rationale for all services
- Explain the "why"
- Necessary for each service provided with 3rd party payers
- Allows reviewer to understand what the doctor is thinking
- As though answering the patient’s question, "Why are you prescribing X?"

Use Caution When Prescribing

- Outcomes like relaxation, stress relief, or improved physical conditioning are CA, not MN
- You must have an Active Tx Plan with specific deficits and goals for third party payers
- Treatment must be aimed at improving function

Basic Treatment Plan:

Todd’s treatment plan for this episode begins on 11/5/2015 and is projected to be completed by 11/5/2016.

- Chief Complaint: pain and stiffness in the back of the neck
- Primary Treatment: Divided and Activated Chiropractic Manipulative Therapy (CMT) (approx. 10 to 24 visits) to the cervical spinal region; a frequency and duration of 3 visits per week for next 4 weeks followed by a reassessment in 30 days to determine the necessity of ongoing treatment
- Supportive Therapy: To optimize the treatment effectiveness, the following supportive therapy is ordered:
  - Ultrasound (70230): ultrasonic with contact medium to be applied to the bilateral to the cervical area and left thoracic shoulder regions for 3-4 minutes per region to address limited joint motion and to decrease pain by 50% during the relief phase of treatment. Initial frequency and duration 3 visits 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 11/5/16
- 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 instructed 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:
  - TX Effect: Examination performed without incident
- Next Visit: Patient achieved continue with treatment plan as scheduled

Treatment Plan is the Sum of Its Parts

- A comprehensive Tx Plan helps to prove medical necessity
- The Tx Plan will 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 for PT services are not much different from CMT
- The note must reflect ALL the care provided
- Help the reviewer 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 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

#### 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/NPI approval of the plan and recertifications when records are requested 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 220.3.19).
- Treatment Notes for each treatment day (may also serve as Progress Reports when requested information is included in the note).
- 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

- Tx consists of a prescribed program to relieve symptoms, improve function and prevent further disability for individuals disabled by chronic or acute disease or injury
- Tx may include various forms of heat and cold, electrical stimulation, therapeutic exercises, ambulation training and training on 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

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 still include the time spent on the modality

Use of Ice-Cold Therapy

- Causes vasoconstriction (shrinkage of blood vessels), decreases blood flow to an area, and slows the body's metabolism and its demand for oxygen.
- The therapeutic goals include: reduce edema, ease inflammation, and block 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.

CBP Doctors Beware!
Interferential Therapy (IFT)

- Used to relieve musculoskeletal pain and increase healing in soft tissue injuries and bone fractures
- Two medium-frequency, pulsed currents 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, sometimes clock time in and out

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:
  - Speeds up the healing process by increasing blood flow in the treated area
  - Decreases pain by reducing swelling and edema
  - Gentle massage of muscles, tendons, and/or ligaments in the treated area
  - No strain is added and any scar tissue is softened

Low-Level Laser Therapy

- Non-invasive light-source treatment that has no heat, sound or vibration
- Reduces duration of inflammation and enhances specific repair and healing processes
- Has been proven to provide pain relief, reduce damage due to the injury and loss of function

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 12-18 visits within a 4-6 week period
- Exercise without a physician or therapist present and supervising = Not Covered

Neuromuscular Reeducation-97112

- Therapeutic procedure 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 12-18 visits within a 4-6 week period.

Therapeutic Activities-97530

- 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

• Soft tissue mobilization through manipulation
• Skilled manual techniques (active and/or passive) applied to soft tissue to affect 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

Instrument Assisted Soft Tissue Mobilization (IASTM)

• Augmented soft tissue mobilization is 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, 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
• Need something different from or in addition to CMT adjustment code
• Difficult to administer CMT due to spasm, swelling, tenderness

What Can Active Muscle Work Help?

• Loss of 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 TMJ 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 60 minutes for 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

AMA/CPT Says “Each 15 Minutes”

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>97102</td>
<td>Therapeutic Massage each 15 min.</td>
<td>1</td>
</tr>
<tr>
<td>97162</td>
<td>Therapeutic Massage each 15 min.</td>
<td>2</td>
</tr>
<tr>
<td>97163</td>
<td>Therapeutic Massage each 15 min.</td>
<td>3</td>
</tr>
<tr>
<td>97164</td>
<td>Therapeutic Massage each 15 min.</td>
<td>4</td>
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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 time-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 → 2nd Billable Unit

Speed Round!
6 Minutes of Therapeutic Exercise

- Do NOT bill a CPT code
- Threshold not met
- Document the chart to include the exercise performed and note there 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

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 care
- Don’t let the lack of documentation cause you problems
- Where much is given...much is required!
Need Help?
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