

Medical Documentation and Billing

Everything you do should be designed to make sure you get paid as much as possible with as little problem as possible. That's not to imply that you should over bill or be dishonest in your efforts, just make sure you dot every i and cross every t.

Following the theme that everything you do should be taken from the standpoint of "selling" you have to approach billing the same way. This is different from collections and if done properly it will reduce your collection problems significantly. Remember, everyone wants the same thing - your money! Everybody loves the work you do especially when you do it for free or for peanuts. It does make you a nice person and a likeable doctor but it doesn't go far to pay the bills. On the other hand, you don't have to be a crook, greedy miser or penny pincher. What you need to do is make sure you "sell" the person who is paying your bill on the concept that it's much better to pay you fairly than try to take your chips off the table and into their own pocket.

The first part of this is documentation. Later, in the "office Forms" and "Patient Forms" sections we will discuss actual forms but the underlying concepts are important to understand first.

Documentation is designed to tell what you did, what positive effect it had and why you should get paid. Too many doctors do the work and don't know how to prove that they should get paid. They've "borrowed" forms from many places that leave gaps in their paper trail or simply don't do enough to convince someone else that your efforts deserve payment. Sometimes it's a simple matter of letting the other party know that you know the law and will accept nothing less than is due you and you know how and are willing to fight for what you deserve.

Documentation Puzzle

To get paid you need to think of the process as a puzzle. You can always get denied, reduced or ignored but if you have all the puzzle parts together you stand a much higher probability of getting paid initially or upon complaint - especially if it goes to court.

What Targets Your Claim For Review?

1. High Level Evaluation and Management Codes. You may get paid more but are you really dealing with life threatening situations or massive injury or multiple disabling conditions? If you don't understand the proper examination codes you will stand out and be "Red Flagged".
2. Multiple Physical Medicine Procedures on the Same Encounter. There is rationale for multiple therapies on the same procedure within reason. Divergent areas require specific therapeutic applications. Some therapies augment each other. Workers' Compensation in California limits it to 4 (2 hands on procedures plus 2 unattended modalities) per visit which is usually realistic. However, even in a WC case additional therapies can be done WITH prior authorization and reasoning for divergent body regions. When it becomes unreasonable it becomes questionable and declinable.
3. Out of Phase Treatment. This is when a therapy generally accepted for a particular phase of healing is used in the wrong phase. Heat in the early stages of an acute injury is inappropriate. Ice is generally no longer an accepted therapy, especially in the later stages of recovery.
4. Same Treatment Plan for All patients Without Regard to Condition. The same treatment plan on every visit for the majority of treatment visits per individual either doesn't consider the phase of healing, the therapy itself or smacks of lack of protocol planning. As long as the therapy can be shown to continue the healing process it can be accepted.
5. No Decrease or Change in Treatment Frequency Based on Recovery Phase. Three times a week for 24 weeks just doesn't make sense. Initial daily or 2 x Day for acute injury and high pain levels

changed to 3 x week for reduced pain and increased patient ability, then 2 x week for minimal pain and increased patient ability, etc. does make sense.

6. Long Term Care for Non-Complicated Conditions.
7. Old Date of Onset on Claim Form. If it's an exacerbation (flare up) of a pre-existing condition give the exacerbation date instead of the original date.
8. Unusual Diagnostic Testing Procedures. The tests should be clinically warranted and acceptable to the general realm of health care providers. New, untested, ones generally generate problems.
9. Repeating Diagnostic Tests. Change from abnormal to normal should be tested for but getting normals over and over again lack the medical necessity of doing the test. Too frequent testing is considered unacceptable. Tests, when conducted, should be timed to allow for change if it is being considered.
10. Long Term Disability. This is the last thing an insurance carrier wants. As soon as they see this pattern developing they are going to shake the tree and see what happens. The goal of all care should be recovery. If it's not to be expected you better document and get outside opinions as to it's validity.
11. Chronic Conditions Under Maintenance/ Supportive Treatment.
12. Canned Progress Reports.
13. No Progress Reports.

Do you need to give reasoning for every treatment on every visit as written in progress notes? NO! Nobody in a reasonable mind (think judge in a hearing) would expect any doctor to write a full case history and continually repeat the same findings, reasoning and expectation on every visit. What is expected is to have at least one time, location, and written documentation for reference. It can be as simple as a detailed therapy page that is given to the patient describing the therapy, it's effects, why it's being used, it's expected results and the normal timing of use along with specific guidelines and reasoning for use beyond the normal duration of therapy. As the patient condition changes significantly (think measurably) that documentation changes. Is that expected to happen on every visit? No. However it is reasonable that there is a measurable change either in physical or medical findings or patient history (description of condition and it's effect on their life activities) every few weeks. At those times you should be doing a re-exam and charging for it with the proper E&M code so long as you document the exam, what was tested, what was found and what it's significance is (possibly a change in therapy or frequency or expected duration).

That's sounds like a lot but what does it really do? It lets you sit down one time and create a form with fill in blanks or check boxes and then simply copy it off for each new patient. Set the page up for individualization specific to specific patients (fill in the blank). Make sure you have another form explaining your new treatment plan (again, a form with check boxes and fill in the blanks). Once it's done have the patient sign it to acknowledge having been given the information. Don't have time to do it yourself? Fine, once it's written down you can easily have a staff person read and describe it to the patient. This frees up your time.

What is it's effect. The patient knows in advance what to expect, why and more importantly when to know he or she is improved to a measurable point for progress to a different therapy and/or treatment schedule. In addition, being able to send a copy of this to any payer solidifies your reasoning for the scheduled therapy and puts the adjuster or attorney on notice that you have a defensible position acknowledged and understood and agreed to by the patient. It makes it much harder for them to deny your treatment plan, try to turn the patient against you or deny payment when it's time to submit bills. What you are doing is "selling" them on the notion that you are doing what's proper, can document and defend it in court if necessary and expect to get paid with little hassle. In some states, including California in Workers Compensation, by giving advance notice of your treatment plan through this method it begins a 60 day limit as to the adjuster's ability to deny the care. Each time you send one of these they have a specific number of days to deny the plan or it is considered by the courts to have been approved and

thereby it's payable if later contested. Think you may have to order an MRI? Put it as a possible alternative diagnostic procedure that may be ordered if improvement isn't as expected on the very first treatment plan. Once the time limit has passed, if the patient hasn't improved and you determine it's necessary you already have blanket permission *because it wasn't denied within the time limit set by law*. You don't need new authorization.

What do your daily SOAP notes have to reflect? That you say the patient was treated, the treatment as previously prescribed was done and that progress will be evaluated from time to reasonable time to consider changing treatment plans as warranted. You don't have to have daily progress proving care. Consider this - if on every visit the patient says they are "feeling better" and you write that in the SOAP notes, at the end of 20 visits how much better are they? What you need is reasonable reevaluation which you bill for and get paid for in order to render an updated medical opinion. Within your SOAP notes you have to show date, patient treated, therapy rendered, abnormal, unusual or extraneous comments rendered by the patient that add to the total image of the case. Quite often these are not any different than the previous day so you can simply note in the SOAP section "Same" and be justified in that. Just don't continue to do it for weeks on end without reevaluations to show you are looking for change and considering updating treatment plans.

Your goal is to be able to paint such a tight picture of why the patient needed the care you rendered throughout the entire treatment schedule and how effective it was that a reasonable person (a judge) would find in your favor if it was presented to the judge. When an adjuster sees this picture developing they have a much harder time justifying their denial of your bills. Hence, you get paid more money and more easily than most doctors.

Billing and CPT Codes

It is not for this treatise to explain all the CPT codes and their proper applications. However a few comments, generalizations and specifics will help you in this process.

One of the biggest problems adjuster's have with many doctors is their use of Evaluation and Management (E&M) codes. All too often, a doctor tries to get just a few more dollars by coding at a lightly higher level than is warranted. Any doctor should really take the time to learn the real significance of the specific words used in the CPT descriptions for E&M codes. Most importantly, is the patient coming in with headaches, cervical pain and associated cervical and thoracic subluxations really in a life threatening condition? Is it one that requires significant analysis as compared to several other serious conditions that could be masked or related? Is it really significantly multiple body regions? Not really. Then don't try to get more than you should. It only red flags the case and sets the adjuster against you at the outset. Have you ever wondered why the medical establishment takes your BP, T°, Height and Weight on every visit? It's because the definition of an expanded exam has to include multiple body systems and each if these counts as one. If you don't do them, don't charge for them. If you want to charge for them, do them, document them and their significance to your examination process.

One question many doctors ask is how do I bill for multiple therapies on multiple areas? That's the wrong approach. Therapies are billed based on time. If it is reasonable that you can do adjacent areas (thoracic and lumbar) at the same time (i.e. EMS & heat) you can't charge for each area. Each therapy can be charged but only for the time allotted. Don't try to extend the treatment time on purpose. The insurance industry has accumulated hundreds of thousands of case studies showing the "normal" treatment time per therapy and region. If you extend it without relevant defensible documentation you're going to get cut. On the other hand if you can document something like EMS and heat to the thoracic and lumbar regions jointly AND the anterior left shoulder these are separated enough to warrant separate application - one following the other - and is billable separately.

The following CPT codes are described and listed with the corresponding HCFA (Medicare) billing amounts (When available). You should remember that those billable amounts reflect a reduced rate below standard workers' compensation and general health billing rates. Refer to your own CPT coding guidelines in your area or consult with another practitioner in your area to get a feel for appropriate billing amounts.

When a description states “. . . each 15 minutes. . .” that means each period of time UP TO 15 minutes. Therefore a 20 minute session would be billed as two line items at the same amount so long as the SOAP notes validate the procedure, areas or topics covered and the time spent providing the service.

An important concept to recognize is that many procedures or modalities overlap in what they do. Think of doing trigger point therapy - applied and sustained pressure on muscle micro spasms to cause a release of the spasm and a retraining of the set point back to normal. It may be done with the patient immobile or while being moved or stretched. Is this massage, therapeutic procedure, neuromuscular reeducation or massage? It actually fits somewhere in the overlap of them all. (Think of overlapping circles.) Since it doesn't have a code of it's own and it isn't specifically described under any of the four codes it's in limbo. There are other therapies and codes that work the same way. That's actually a good thing.

You could code and bill it for massage but it may be denied on the basis that the payer doesn't pay for massage as a therapy. If this occurs you can ask the adjuster to answer yes or no to which of the codes they do pay. If one is answered yes you can correct your billing, recode the therapy and rebill to get paid. On the other hand you should have a procedure to call at the beginning of care to see what codes the adjuster does pay so you can code it properly to begin with.

Another example would be specific exercises you would have the patient do while in your office. If you put them on a wobble board and have them also doing other exercises, which do you bill for if the total time is less than 15 minutes? Check with the adjuster. The black bordered box is simply an illustration of some linked codes.

CPT-4	Description	Billing \$
97110	<u>Therapeutic Procedure</u> Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	28.64 times # of units
97112	<u>NeuroMuscular Re-Education</u> Therapeutic procedure, one or more areas, each 15 minutes ; therapeutic exercises to develop strength and endurance, range of motion and flexibility neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities (<i>May include balance or wobble board</i>)	30.01 times # of units
97124	<u>Massage Therapy</u> Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	22.48 times # of units
97140	<u>Myofascial Release</u> Manual Therapy each 15 min	26.79 times # of units
97530	<u>Functional Exercise</u> (Kinetic Activity) May be used in place of 97110 or 97112	

97150	Therapeutic procedure(s) , group (2 or more individuals)	21.29 times # of units
97535	ADL Self care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes (May be group setting)	21.84 times # of units
97537	ADL Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis), direct one on one contact by provider, each 15 minutes (Use for one on one setting)	28.35 times # of units
97535	Self-care management training (15 minutes)	\$21.84 each 15 minutes
99372	Telephone call by chiropractor to patient, rehabilitation professional, physician, or any other medical provider or medical coordinator, 15 to 30 minutes	45.00
99052	After Hour Services between 10 p.m. and 8 a.m. (in addition to regular billing) <i>(Also, includes weekends)</i>	26.26

The last three codes illustrated here are ones you should become familiar with. In California hundreds of doctors in seminars have all answered this question with the INCORRECT answer.

If you had a patient call you at home on a Saturday night at 9:30 pm as you were about to get into bed after working hard all day and the patient stated that they needed your care immediately since they had been playing earlier in the day and now their back was so bad they couldn't move let alone sleep and you needed to come to the office so you could fix them. What would you do? What if you were having a very slow month and needed the extra income? What if it was a Workers Compensation case and your state limits the number of line items that can be billed on each visit (California limits it to 4 therapies per visit)?

Some doctors have said, "Tell the patient to take two aspirin and call me Monday morning." Some have said they would either have the patient come to their home or they would actually go the their office to take care of the patient.

Instead of going to the office, you might decide to explain how to use heat or ice, or self applied trigger point therapy with a tennis ball or how to stretch, or tell another family member how to deal with the "emergency" over the phone. Once you get back to the office on Monday, pull the patients record and document the date, time patient called you regarding condition, your consultation with him and bill it using the last three codes on the table. You don't have to write a treatise on everything you said. It can be a brief as, *"Patient phoned me at home Saturday night at 9:30 regarding exacerbation of back pain and severe muscle cramping. Discussed the condition, recommended and explained home therapy and ordered patient to return to office on Monday morning."*

By the way, look up the definition of after hours care. There are actually 3 different levels. Essentially it's anything outside normal patient scheduled time for your office. Think about this. Have you ever had a patient call you to tell you they were in pain but couldn't make it in for their scheduled visit so you gave them some advice over the phone as th what to do until the could get in? Phone consultation time. What about a patient that shows up at 11:58 to check in for their morning appointment and they aren't ready to

see you until 12:02? Your normal patient treatment time is 9:00 am to noon then again in the afternoon. 12:02 is outside of normal patient treatment time. It should be billed as such - legally and ethically! But you weren't going anywhere anyway. That doesn't matter! You did have a very important lunch appointment to get to and this delay held you up. Your McD burger is getting cold and now you'll have to scarf it down without the quiet enjoyment of the full lunch experience. Document the patient's lateness and the after hours care and bill for it. I had a doctor in an all day seminar have to leave the room three times to answer a phone call from a patient in pain. When I explained this she let this big smile grow and said, "You mean I can bill for these calls?" YES!

Another problem arises because most doctors don't understand the definition of E&M. Go to your CPT code book and read the definition. You will find it interesting. Evaluation and Management IS NOT therapy. Anything that is not therapy is E&M and the California WC (check your own state) limits the number of line items as 2 procedures plus 2 modalities for a total of 4 therapies. Anything else that's done is considered an E&M activity and should be billed with the -52 modifier. This modifier simply states that the activity is an E&M activity performed on the same visit by the same doctor as other therapeutic or E&M activities were performed.

Another illustration most doctors have the wrong answer for is in WC again. Because of the above limitation they try to schedule visits for therapy on different days than exams but sometimes get cut because it doesn't make sense to the adjuster. Or else, they just don't do things and write off the billing. Listen to this scenario and see if you recognize parts of it in your own experience.

A WC patient started with you one month ago and was in so much pain you placed him on temporary total work restriction. Today, one month later, he has been getting better and you expect to be able to send him back to work on a Temporary Modified Work Restriction so long as he has a back brace while working. Before the patient comes in you call the adjuster, discuss your expectation and ask the adjuster to call the employer to make sure the modified work restrictions can be adhered to and also to get authorization for the back brace.. The patient comes in, you exam him to make sure he can return to work, counsel him on how to work, lift, rest, deal with pain at work, etc.(it took your staff person or you 35 minutes to cover all the work changes, make sure the patient fully understood how to do each action and actually practice the movements, and all the details involved so he won't re-injure himself) then do your therapies and send him on his way with your restrictions.

Question: How many line items can you bill for? 4 - the therapies based on the limitation - WRONG!

If you look at the following table you'll see the 10 line items you can bill for. Items 1 - 4 are the therapies you did. #5 is the pre-authorized back support. It isn't reasonable to change treatment plans and send a patient back to work without an examination so #6 is the re-exam. Any time there is a change in the patient condition you are required to submit an updated physician's report (#7). Since the modified work training is classified as training in Activities of Daily Living (ADL) it is a management activity (E&M) not a therapy and is billable as line #8. But since it took more than the allotted 30 minutes (WC is 30 not 15 minutes) you have to bill it again for the remaining 5 minutes (time period or any portion thereof) for line #9. The call to the adjuster was necessary in the management of the case for both the back support but more importantly because it's his job, not yours, to call the employer to verify work modification. That keeps him in the loop and makes it easier to keep the patient on Temp. Total WR if the employer can't modify the work. That's line #10. All this, if documented, makes sense and will be paid. It's according to the law.

Billing 10 line items for Workers' Compensation - Use the -52 modifier for non-therapy lines

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|----------|-------------------|------------------------|
| 1. TX #1 | 5. Back Support | 9. ADL 5 minutes |
| 2. TX #2 | 6. Re-exam | 10. Phone Consultation |
| 3. TX #3 | 7. Report | |
| 4. TX #4 | 8. ADL 30 minutes | |

Another “unknown” thing most doctors lose money on is the idea of ADL within your office. The definition is based on anything that will help them to recover that they can do outside of the office - one for personal time activities and the other for WC situations. The definition of the time allotment is NOT the 15 or 30 minutes most doctors think. It is anytime UP TO the maximum time limit before you have to rebill for additional time. Have you ever had a patient getting a little better so you advised and showed him how to do some simple slow deep toe touch bends to strengthen the lumbar region? How long did it take? It doesn't matter. That's ADL. Bill for it. By the way, let the patient know you will check on their progress in one week to alter the number, speed or pattern of the exercise. Now, next week you can bill for ADL again. How many times do you average per week doing this for FREE? You're a doctor. You get paid for your knowledge and expertise, not for your hourly wage.

By the way, if you do this kind of activity with two or more patients at the same time to cut down on the total time spent (you can even have your staff do it) you can bill it as the 97150 on multiple patients that participated. If you hold some kind of in office workshop that you have patients attend, you can bill it with this code. Make sure you read it to understand it's use.

Ultimately in this section I've tried to give you some examples of how you lose money for doing things that other experienced and better trained doctors get paid for. Adjusters pay these bills all the time. You just have to do a little research and read the CPT coding book you have or get one fast! It's worth thousand of dollars per year you're losing right now.