Medicare Documentation and the LCD

Will you documentation meet Medicare's requirements?

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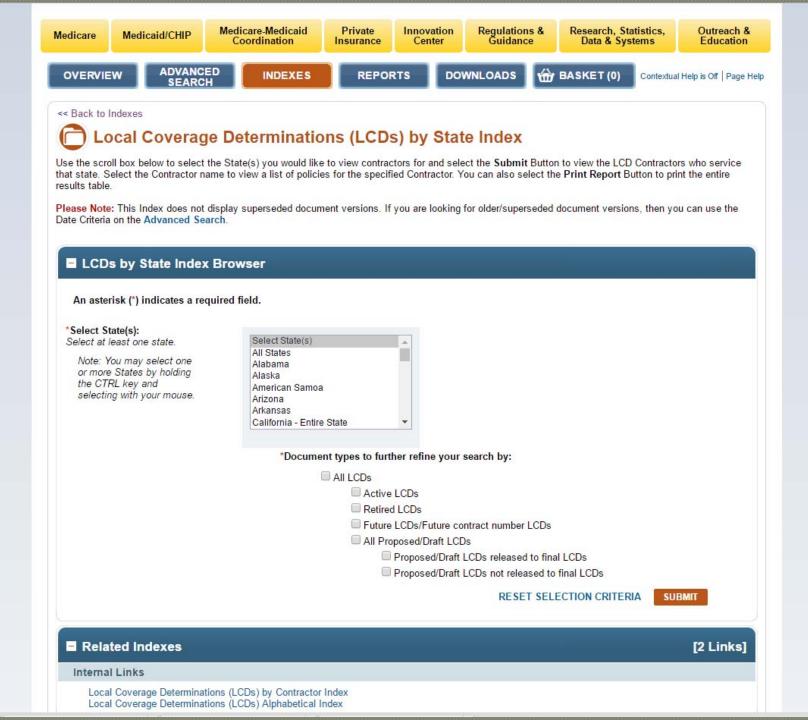
Objectives

- Understand what is covered by Medicare and the definition of Maintenance care.
- Understand the importance of the LCD and where to locate the LCD for your state.
- Understand what the documentation requirements are for providing services the Medicare covered beneficiaries.

Local Coverage Determination

Local Coverage Determination

- Gives you the specifics required to bill, document and provide Chiropractic services to the Medicare Beneficiary
- https://www.cms.gov/medicarecoverage-database/indexes/lcd-stateindex.aspx?bc=AgAAAAAAAAAA %3d%3d&



Medical Necessity

Medicare Coverage

• Medical Necessity:

• Title XVIII of the Social Security Act, Section 1862 (a)(1)(A). This section allows coverage and payment for only those services considered medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member

Medicare Coverage

• LCD-Medical Necessity

- The patient must have:
 - Significant health problem in the form of a neuromusculoskeletal condition necessitating treatment
 - Manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function
 - Subluxation of the spine as demonstrated by x-ray or physical exam

Medical Necessity

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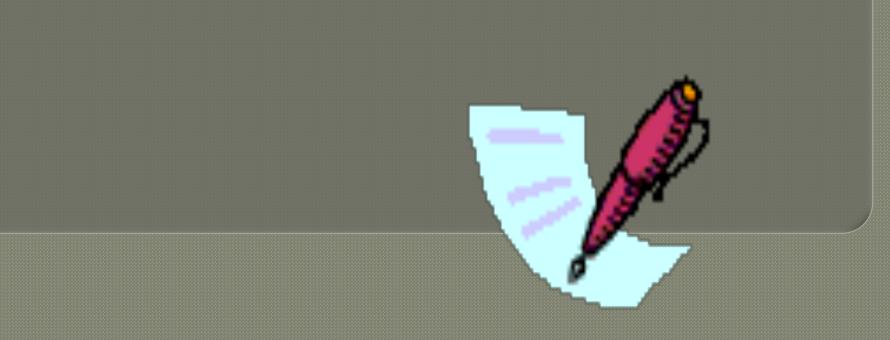
 Assures services to Medicare patients are reasonable and necessary for diagnosis or treatment of illness or injury

Remittance Remark Code

CO-50 Medical Necessity Denial

Medical Necessity Denials

- Some services are only covered in some instances
 - Example: Chiropractic Manipulation
 - ONLY covered for a diagnosis listed in LCD
 - Any other diagnosis will be denied as not medically necessary



Documentation Guidelines

Medical Necessity Documentation

- Written documentation (office records, diagnostic test results, etc.)
 - Do not submit with claim
 - Send to Medicare when requested
- Statement or diagnosis of just "Pain" not sufficient to support medical necessity

Medical Necessity Documentation

- Precise level(s) of subluxation(s) must be specified for each spinal region manipulated
 - List exact bones (C5,C6)
 - Area/Region if it implies only certain bones
- Use terms that are clearly understood to refer to bone/joint space or position
- Document the need for an extensive/ prolonged course of treatment
 - Must be appropriate to the reported procedure code(s)

Documentation of Subluxation

- X-ray
 - 12 months before/three (3) months after
 - CT/MRI
- Physical Exam
 - Pain/tenderness
 - Asymmetry/misalignment
 - ROM abnormality
 - Tissue, tone, texture and temperature changes
 - Must have 2 of the 4 mentioned above / 1 of these must be Asymmetry or ROM abnormality

Documentation of Direct Relationship

- Mechanism of Injury
- Chief Complaint
- Identify the Subluxation

Documentation Reasonable Expectation

- Age of the Patient
- Comorbidities
- Prior Level of Function
- Measurable Goals
- Keep it Realistic
- Terms that relate to the patient's necessity for treatment



Documentation of Initial Visit

- All Components of History
- Evaluation
- Diagnosis
- Treatment Plan
 - Recommended Level of Care
- Signature

Documentation of History

- Symptoms: What brought the patient in?
 - Acute injury/trauma
 - Chronic condition.....why now?
- Prior Level of Function
- Health and Relevant Family History
- Patients Age
- Comorbidities

Documentation of History

- Previous Occurrence?
 - What worked, what failed?
- Detailed Descriptors of Symptoms
 - Quality
 - Onset
 - Duration
 - Intensity
 - Character
 - Location
 - Radiation
 - Frequency
 - Other?

Documentation of Subsequent Visits

- Link back to Treatment Plan-review
- Measure
 - Progress towards goals
 - Changes since last visit
- Exam
- Evaluate
- D/C when no further progress (or give an ABN)

Documentation of a Treatment Plan

- Treatment Plan
 - Date of initiation of treatment
 - History of prior treatment
 - Means of measuring progress towards goals

Documentation of a Treatment Plan

- Treatment Plan
 - Individualized
 - Patient-centered
 - Realistic
 - Reasonable time-frame
 - Tolerance

Documentation Keys To Remember

- Review your specific LCD
 - It is an open book test
- Your documentation is on going
 - Must continue after the first visit
- Treatment plan
 - Have one
 - Update it regularly
 - Follow it
- Use PART
- Identify maintenance and bill it appropriately

Questions?

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