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Documentation 101 – Part 7 of 10

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BASIC UNDERSTANDING OF PARTICIPATING VS. NON-PARTICIPATING CHIROPRACTIC PROVIDER FOR MEDICARE:

Participating:
1. Medicare fee schedule is 5% higher.
2. Provider is paid 80% of the approved amount of the participating fee.
3. Provider is listed in the Medicare directories.
4. Provider is not subjected to the limiting charge.
5. Provider agrees to accept assignment for all covered services for which payment is made under Medicare Part B i.e.: CMT Codes 98940, 98941, 98942.
6. Provider who accepts assignment agrees to accept the Medicare approved amount as payment in full. Note: Deductibles, co-payments may be collected as well as any non-covered service can be collected.
7. Provider is paid directly from Medicare for covered service and Medicare automatically forwards claim to secondary insurance (Medigap) and secondary insurance must pay provider directly for any covered amount due under the (Medigap Policy). Note: To insure secondary payment will be made directly to provider he/she should have the patient contact their secondary insurance company and find out if their plan offers a cross over program. If plan offers program patient needs to request insurance company to activate program.
8. Provider agreement is for 1 year and is bound by that agreement until he/she terminates the agreement in writing during the enrollment period.

Note: This would be done toward the end of the calendar year.

Non-participating:
1. Provider does not sign an agreement he/she may selectively accept assignment or not per individual claim. Note: Each claim would be considered a separate contract.
2. Provider is paid 80% of the non-participating fee which is 5% less than the participating fee.
3. Provider may charge up to but not exceed the limiting charge determined by Medicare for all covered services which payment is made under Medicare Part B i.e.: CMT Codes 98940, 98941, 98942.

4. Provider may collect any and all non-covered services not covered under Medicare Part B.

5. Payment is made directly to the patient unless the provider selectively accepts assignment.

6. Provider can be sanctioned if he/she exceeds the limiting charge i.e.: Possible exclusion from the Medicare program for up to 5 years, assessment up to 3 times the amount overcharged and $10,000.00 for each item or service involved.

**Patient Hotline:**
Specific phone number for patients to contact Medicare concerning claims questions and/or any other Medicare related issues 1-800-462-9306.

**DETERMINING WHEN DIAGNOSTIC TESTING IS APPROPRIATE:**
Diagnostic procedures should only be considered after a complete medical history and complete physical examination was performed and the physician determines that the diagnostic testing would be medically necessary in order to further evaluate the patient’s medical disorder as well as significantly affect the patient’s treatment protocol.

**COMMONLY USED DIAGNOSTIC PROCEDURES IN CHIROPRACTIC PRACTICE:**

1. Plain film x-rays-It is the most widely utilized skeletal imaging method. Primarily used to rule out fractures, dislocations, anomalies or bone pathology as well as used in biomechanical analysis. The doctor should take into account some of the following guidelines for performing skeletal radiographs.

**Probable Indicators:**
- Trauma-both recent and hold
- Assessment of joint instability
- Unexplained weight loss
- Night pain
- Neuromotor deficit
- Inflammatory arthritis
- History of malignancy
- Fever of unknown origin greater than 100F
- Abnormal blood finding
- Deformity i.e.: scoliosis
- Failure to respond to therapy
- Medical legal implications

**Possible Indicators:**
- Greater than 50 years old
- Drug or alcohol abuse
- Corticosteroid use
• Unavailability of alternate imaging
• Unavailable, lost, outdated or non-diagnostic previous x-ray studies
• Research
• Systemic disease

Non-Indicators:
• Patient education
• Routine Screening
• Habit
• Discharge status assessment
• Routine biomechanical analysis
• Pre-employment
• Physical limitations of patient
• Financial gain
• Patient recently exposed to high levels of radiation exposure
• Pregnancy

2. **Tomography**-Primarily used to obtain specific images of anatomy and its abnormalities that are not accessible by plain film x-rays. It also enables the physician to obtain specific images of selected levels in the body by blurring out all structures above and below the selected level in question.

3. **Radionuclide Imaging (Bone Scan)**-Primarily used to detect skeletal metastasis, tumors, infections, arthritis, fractures (occult, stress and recent fractures), and avascular necrosis. Done by injecting a radioisotope intravenously and waiting various time periods to record areas of increase uptake (hot spots). In addition, there are other areas that can be evaluated i.e.: brain, heart, lung and kidneys.

4. **SPECT (Single Photon Emission Computed Tomography)**-It is a combination of tomography and bone scan. Primarily used to evaluate areas within bone or areas where bone overlap i.e.: pars interarticularis.

5. **Myelography**-Primarily used to diagnosis disc, vertebral canal (stenosis), spinal cord and nerve root disease. Done by injecting a water-soluble contrast media into the subarachnoid space.

6. **Discography**-Primarily used to evaluate disc pathology i.e.: degeneration, disc architecture, pain response and disc resistance to injection. Done by injecting a water-soluble contrast media into the disc under fluoroscopic control.

7. **Ultrasound**-Primarily used to diagnosis abdominal, pelvic and vascular disease i.e.: soft tissue masses (cystic or solid).

8. **Computed Tomography (CT-Scan)**-Primarily used to evaluate the CNS. When evaluating the skeleton it aids in detecting neoplasms, trauma, infections, metabolic disease and spinal syndromes.

9. **Magnetic Resonance Imaging (MRI)**-Primarily used to evaluate soft tissues i.e.: discs (degeneration, bulges, herniations), ligaments (tears), muscle, spinal cord (tumors), nerve roots as well as bone marrow, joints, spinal canal and/or lateral recess, intracranial disease and CNS disorders i.e.: multiple sclerosis. In addition, intravenous contrast (gadolinium) will enhance areas of increased vascularity i.e.: neoplasm,
inflammation and scar tissue.

10. **Bone Densitometry**—Primarily used to measure true mass of bone, predict the risk of future fractures and monitors the effectiveness of treatment.

11. **Paraspinal Ultrasound**—Primarily used to detect muscle bleeding and inflammation.

12. **Thermography**—Primarily used to evaluate sensory/neural abnormalities and myofascial irritations.

13. **EMG (Electromyography)**—Primarily used to evaluate muscle and nerve (neural function) i.e.: irritation.

14. **NCV (Nerve Conduction Velocity)**—Primarily used to evaluate peripheral nerve injuries and diseases affecting the peripheral nervous system.

   **Note:** Usually performed after the first 30 days or acute period of treatment to obtain an accurate reading.

15. **SSEP (Somatosensory Evoked Potential)**—Primarily used to evaluate peripheral cutaneous receptors and the primary somatosensory cortex.

**THINGS TO CONSIDER WHEN INTERPRETING PLAIN FILM X-RAYS OF THE SPINE AND OR EXTREMITIES:**

It should be noted that there are many different ways to evaluate and interpret radiographic films of the spine and there is no one method that is considered better than another. Interpretation/evaluation depends on the individual and what best suits them. What is important is that the physician use some kind of systematic approach to evaluate all aspects of the film. With this in mind, there are some key factors that are considered important and are listed as follows:

- Always have access to the appropriate clinical information i.e.: patient intake form, case history, past medical history, family history and physical examination findings.
- Identify the x-ray views taken, always have opposing views available and be certain films are of high quality.
- Do a quick scan first and give your initial impression i.e.: normal/abnormal, congenital/acquired.
- Identify and evaluate alignment and all bony structures.
- Identify and evaluate all areas of cartilage (joint spaces).
- Identify and evaluate all soft tissue structures.
- Always try to obtain any prior films for comparison.
- When done reviewing films it’s good to stop and come back a few hours later to review films again. This acts as a safety feature to double check yourself.
- Indicate radiographic findings in record and radiographic diagnosis if known.
- Refer out for additional diagnostic studies and/or laboratory tests if clinically and medically necessary in order to further evaluate and make the proper diagnosis.
- Always keep in mind the five radiographic densities i.e.: air, fat, water, bone and metal. In addition, it is very important that you know what normal anatomy is in order to detect abnormal anatomy. Remember you are held responsible for whatever findings are on the films.