Differentiating
Maintenance Care vs. Supportive Care
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Remember the results of the 2005 OIG report “Chiropractic Services in the Medicare Program: payment Vulnerability Analysis”? One of the main issues was billing for maintenance services:

- **Maintenance Services**
  - “Maintenance services were the most common type of noncovered chiropractic services that Medicare paid for in 2001”
  - 57% of all services billed were deemed maintenance services.
Differentiating Maintenance Care vs. Supportive Care

Most health plans offer chiropractic coverage as a core benefit for its members. Typically the benefit doesn’t cover chiropractic services that are experimental, investigational of unproven efficacy or care considered maintenance care. Understanding the terms maximum medical improvement, maximum therapeutic benefit, supportive care and maintenance care is crucial in today’s 3rd party reimbursement system. It can help you avoid audit and recovery processes or being investigated by the OIG which can carry hefty fines and potential licensing board sanctions.
Before we can discuss the difference between maintenance care and supportive care, we need to review some definitions:

- **Maximum Medical Improvement (MMI)**
  - A condition that has reached a clinical end point at which no significant improvement in the baseline can be reasonably anticipated. For most patients, their conditions have either completely resolved, or no longer require supervised intervention.
Differentiating Maintenance Care vs. Supportive Care

- **Maximum Therapeutic Benefit (MTB)**
  - The application of the present therapeutic regimen has achieved its full potential for the episode of this condition for which it was applied.
  - If the condition has plateaued (reached MTB), and the patient continues to have significant complaints, objective findings and functional deficits, it’s appropriate to consider:
    1. Changing the current treatment approach such as increasing the therapeutic exercise plan (active care) in lieu of or in addition to a predominantly passive care plan (e.g., traction).
    2. Discuss self management with the patient including life-style modifications, injury avoidance, and then discharge the patient or transition into elective care (self pay).
    3. Referring the patient for consultation and possibly a different therapeutic approach.
    4. Reviewing the clinical status of the case to determine if supportive care is necessary.
Differentiating Maintenance Care vs. Supportive Care

- **Supportive Care**
  - Treatment/care of patients having reached maximum therapeutic benefit (MTB), in whom periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains that would otherwise progressively deteriorate.
  - Supportive care is **inappropriate** when it interferes with other appropriate primary care options or when the risk of supportive care outweighs its benefits, i.e. physician dependence, somatization, illness behavior or secondary gain.
  - Supportive care follows appropriate application of active and passive care including lifestyle modifications.

Too many clinicians attempt to transition their patients into supportive or as needed care without fully understanding the parameters for supportive care. Let’s look at the criteria that justifies supportive care.
Differentiating Maintenance Care vs. Supportive Care

Criteria for Supportive Care

- Supportive care may be appropriate when:
  - The patient is at maximum medical improvement (MMI)
  - The patient has been afforded alternative care options prior to or after chiropractic care to reach MMI. These may include but are not limited to medication, physical therapy, exercises, pain management, etc.
  - There is documented controlled trials of treatment withdrawal, which results in significant deterioration of the patient’s condition (not just symptoms but also activities of daily living). The use of objective outcome tools (Oswestry Low Back Index and Neck Disability Index) are useful to measure any deterioration in the patients functional activities. Therefore, the notes have to indicate that the patient was conditionally released with self-care instructions (activity modifications, exercises).
  - The treatment is rendered on an as-needed basis in response to an exacerbation. The visits are not pre-scheduled. and do not exceed 3 visits over a 2-month period.
Differentiating Maintenance Care vs. Supportive Care

**Maintenance Care**

- Some insurance carriers may cover supportive care while others may not. Almost no carriers cover wellness/preventive care for chiropractic services. This is what is typically called “maintenance care.”
- Medicare’s definition is: A treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition. Once MTB has been achieved for a given condition, ongoing maintenance therapy is not considered to be medically necessary.
Differentiating Maintenance Care vs. Supportive Care

- **Maintenance Care**
  - The promotion of preventative care or wellness is a core belief in chiropractic. However, there is little scientific literature to support maintenance care. With the chiropractic profession adopting an evidence-based approach to care, maintenance care at this time remains elective. Because maintenance care does not meet the criteria of medical necessity (most health plans have a provider manual with medical necessity defined) it’s a non-covered service.
Differentiating Maintenance Care vs. Supportive Care

**Maintenance Care**

- So in general maintenance care is a form of elective care (treatment chosen by the patient after MMI or MTB has been reached) whereby a patient presents with any of the following and chooses to obtain treatment:
  - Absent symptoms and/or objective findings
  - With a request for “wellness care” or “preventative services” in order to maximize general health and well being.
  - With residual complaints, objective findings and/or functional restrictions that do not substantially deteriorate with an absence of supervised intervention.

- Clinicians that choose to provide non-covered elective services (e.g. maintenance care) may be able to do so under a self-pay agreement directly with the patient (agreed to prior to treatment rendered). It’s the responsibility of the clinician to ensure that only benefit eligible clinical services are billed to 3rd party payors.
Differentiating Maintenance Care vs. Supportive Care

Sample Chart Entries:

- **Supportive Care**
  - A 56 year-old male is 4 years post-laminectomy at L4-L5. He has had a course of physical therapy and chiropractic care. The patient reached MMI and was released with home exercise instruction and activity modifications and was instructed to return on an as needed basis two months ago. He presents today for an exacerbation of a stable condition due to excessive snow shoveling 2 days ago. The Oswestry disability index indicates the patient finds it difficult to sit for greater than 30 minutes and walk greater than 1 mile without pain. The patient presented with minimal symptoms. The patient was treated today with spinal manipulation along with reviewing his exercise protocol and other self-care instructions. The patient responded well to the treatment. The patient has been able to self-manage with home activities and was instructed to return on an as needed basis.

- **Maintenance Care**
  - “Patient returns today for routine monthly visit. Minimal complaints of stiffness. However patient would like a “tune-up” to prevent regression to how she was when she started care. We are treating today as usual and schedule her for a follow up in 1 month.”
CMT Coding
CMT Coding

Remember the results of the 2005 OIG report "Chiropractic Services in the Medicare Program: payment Vulnerability Analysis"?

- 16% of all services were miscoded or billed at the incorrect level of spinal manipulation.
- 6% of all services billed were undocumented.
- Upcoding was a significant problem, resulting in $15 million overpayment.
  - 69% of CPT code 98942 billed were upcoded
  - 21% of CPT code 98941 billed were upcoded

So what is appropriate CMT coding?
A challenge often experienced by clinicians is choosing procedure codes that most accurately reflect their patients' condition and the services that are provided for their patients. Constantly changing guidelines, misinterpretations, and improper documentation of clinical necessity in order to receive appropriate reimbursement can make choosing the correct codes even more of a challenge.
CMT Coding

- It’s extremely important when billing 3rd party payors that the appropriate level of CMT billed is supported by the patient’s presenting complaint. Practitioners “technique” or “philosophy” is not a relevant factor in determining the level of manipulation to bill to a 3rd party payor.
- If your clinical notes are ever audited to compare billing and payment accuracy and the medical necessity of your services, supporting documentation for manipulation and adjunct therapy to a region (s) should include:
  1. A patient that presents with a symptomatic health problem in the form of a neuromusculoskeletal condition
  2. Presence of a subluxation
  3. Clinical signs and symptoms consistent with the levels of subluxation
  4. A direct therapeutic relationship to the patient’s condition, and
  5. Provide reasonable expectation of recovery or improvement of function.
CMT Coding

For purposes of CMT, there are 5 spinal regions. These are:

1. **Cervical**
   - Includes atlanto-occipital joint, C1-7

2. **Thoracic**
   - Includes costovertebral/costotransverse joints (posterior ribs), T1-12

3. **Lumbar**
   - Includes L1-5

4. **Sacral**
   - Sacrum, including sacrocccygeal joint

5. **Pelvic**
   - Sacroiliac joint and pelvic articulation
3 CMT codes were developed to encompass the 5 spinal regions:

- **CMT 98940**
  - Spinal, one to two regions
- **CMT 98941**
  - Spinal, three to four regions
- **CMT 98942**
  - Spinal, five regions
The following clinical examples are intended to give the clinician examples of clinical situations and appropriate use of CMT codes, but is in no way intended to describe every manipulative procedure of clinical scenario.

- **CMT 98940**
  - A 45 year-old male, established patient, presents with a complaint of right-sided cervicothoracic pain for 2 days after carrying groceries. After a complete examination, manipulation to the cervical (C5) and thoracic (T2) regions was performed and documented.
CMT Coding
Clinical Examples

- **CMT 98941**
  - A 69 year-old female, established patient, presents with a main complaint of headaches with associated cervicothoracic pain and secondary upper lumbar pain. After examining the patient you find subluxations/joint restrictions at C4, T2, L3, and L5. Manipulation was performed at these levels. Note the 98941 code was appropriate with the patient presenting with 3 areas of complaint.

- **CMT 98942**
  - A 47 year-old male, established patient, presents after a fall from a ladder at home. You had the patient complete a Ransford Pain Diagram which supports his subjective complaints and your examination (objective) findings at the cervical, thoracic, lumbar, sacroiliac and buttocks, bilaterally. Manipulation was administered to the cervical (C5), thoracic (T7,8,9), costotransverse joint T9, lumbar (L4,5), sacroiliac and sacrococcygeal joints.
X-Ray Report Writing
Many practitioners consider writing x-ray reports to be too time consuming and onerous. As a result, they either write a brief summary of their impressions or make no written report at all. Not making a report is comparable to performing a physical examination and not documenting the tests or results in the patient’s record.

So why complete an x-ray report?, there are a number of important reasons and purposes:
X-Ray Report Writing – Why?

1. Professional Responsibility
2. Medicolegal Issues
3. Comparison
4. Permanent Record
5. Communication
6. Indications/contraindications
Each clinician interpreting a study is responsible for everything on that study. Therefore, it’s important that we be able to construct accurate, concise and meaningful reports. Remember, as with all aspects of the patient’s file, the x-ray report is a reflection of the abilities and professionalism of the practitioner.
Often it’s the report, rather than the film or verbal opinion, that serves as the legal document in any legal proceeding.
Comparing a recent report with previous reports or radiographs can be useful when the radiographs:

- Have been lost, destroyed or unavailable
- Are very numerous
- Information is urgently needed. The report can be electronically transferred
- Previous report can direct a current investigation and interpretation to a specific site or type of abnormality (i.e., changes in size of a lesion).
Consider the following situation:

A 52 year-old male presents with mid-thoracic pain and a productive cough. The pain has been worsening over the past 3 weeks. You decide that a chest x-ray is appropriate because of the potential red flag of infection or cancer. Upon reviewing the x-ray, a well-defined round opacity measuring 1 cm is seen in the right upper lobe along with a well-defined infiltrate in the middle lobe. Luckily, you were able to obtain a copy of the patient’s previous x-ray reports. A report written 2 years previous also described the same lesion in the same location and same size. Given that it has not changed in size over this time-frame, it most likely represents a benign lesion such as a calcified granuloma. The well-defined infiltrate you determine is most likely pneumonia and you make the appropriate referral.

Hence, a previous report can direct a current investigation and interpretation to a specific site or type of abnormality (ie. changes in size of a lesion). Please refer to the red flag download at this time.
When radiographs are lost, disposed of or not available, the report remains part of the patient’s permanent record. Where a patient’s file is extensive and other studies have been conducted over time, the x-ray report can provide substantive information as to any preexisting conditions.
X-Ray Report Writing

Communication

Provides useful information to any other healthcare practitioner involved in the patient’s care or future care. It may also be used for communication with any 3rd party payors. Hence, it serves to facilitate interprofessional and intraprofessional communication.
X-Ray Report Writing

Indications/Contraindications

By providing a status review of the patient’s condition, clear management directions can occur, i.e. rule out any contraindications. Also remember to link the history and exam findings with the x-ray findings as there is a high incidence of x-ray features that are unrelated to the patient’s complaint.
Medicolegal Implications

Pitfalls of Reports

Sources of medicolegal problems with x-ray reports are numerous. These can be minimized when a standard reporting format is followed, the report is completed with as little distraction as possible, when adequate time is allocated, and when you carefully proofread all reports before signing and/or transmitting somewhere.

Some of the pitfalls include:

- **Failure to produce a report**
  - Whenever an x-ray is taken or any film obtained from outside your clinic, a report should be generated. Without this, the inference could be made that the study was not interpreted or included as part of the patient’s management. Did you miss something on the film?

- **Patient details omitted**
  - Details include patient name, address, gender, date of birth, and any relevant clinical information. This ensures the patient is clearly and correctly identified.

- **Failure to describe study details**
  - Failure to provide study details can be a medicolegal trap. Defining what studies were reviewed and when they were taken ensures that the opinions only relate to those and nothing else. It’s also important to note if no right or left markers are visible.
  - If you are reviewing an outside film, did you mention the quality of the study?
Medicolegal Implications

Pitfalls of Reports

- **Misdiagnosis**
  - Mistakes can occur for a number of reasons. This can be due to failure to recognize something as an abnormality or a normal variant, failure to search fully even after one abnormality is found, and failure to detect a lesion at the periphery of the study. A great reference text to use if you interpret your own films is: “Keats Atlas of Normal Variants”.

- **Failure to suggest further studies**
  - If there are findings that suggest a significant abnormality that needs a follow-up or different views or referral for more advanced imaging and it’s not performed, this could have legal, not to mention health, ramifications.

- **Failure to report study adequacy**
  - Image quality has a direct bearing on your ability to diagnostically read the film. A failure to denote right or left should also be noted. If you are dictating a report on an inferior quality film note that in the report (ie the films are underexposed).
Medicolegal Implications

Pitfalls of Reports

- **Confidentiality**
  - Remember release of the report should be accompanied by the patient’s permission. This can be obtained with written consent.

- **Failure to follow recommendations**
  - If specific recommendations were made, then follow through with them. If not, provide clear, well-documented reasons why this was not done.

- **Failure to review previous reports**
  - Significant information may be found on previous reports. That information may help direct the present review to focus in on a particular area (i.e. previous report discuss what appears to be a benign lesion. The new film can be used to compare the lesions present size etc..)
Creating x-ray reports is an integral part of clinical practice. Developing skill in their formation requires an adequate environment, equipment, interpretive skill, and knowledge base.

Being aware of the errors inherent in the interpretation of studies is important. These are due to analysis of poor studies, lack of knowledge, perceptual errors, reading just the reports and not the film, and failure to access a second opinion if needed. Remember, if a film comes in with a report, look at the film, don’t just rely on the report itself. Failure to provide a report or a report that is inaccurate as part of the patient’s record is a legal liability.
In this age of accountability and medicolegal requirements, clinical records can become a clinician’s best defense tool or their worst enemy.

Maintaining high standards in documentation ensures excellence in both professional practices and patient care. Appropriate documentation has relevance to patients, practitioners, the profession and 3rd party payors.

Information obtained during the initial and subsequent patient visits helps lay the foundation for justifying treatment, diagnostic tests and concurrent care protocols. Information collected should be in an organized format (whether it’s the classic SOAP or a modification of the SOAP format) that allows information to be recorded in a predictable manner using specific headings. Whatever format you use be consistent and thorough.
Summary

- As we learned from the 2005 OIG Report “Chiropractic Services in the Medicare Program: payment Vulnerability Analysis”, we must have a heightened consciousness around record keeping, maintenance care, goal setting and coding. In this age of accountability we need to know what is billable to a 3rd party payor and what the difference is between maintenance care and supportive care.

- We also must be diligent in billing the appropriate CMT coding, not based on our beliefs but based on clinical presentation. Remember that the OIG Report pointed out that after reviewing Chiropractic records:
  - Upcoding was a significant problem, resulting in $15 million overpayment.
    - 69% of CPT code 98942 billed were upcoded
    - 21% of CPT code 98941 billed were upcoded
Summary

- This module also provided a documentation checklist. This form can be used to self-audit your record-keeping procedures by applying this checklist to a random patient file in your office. Applying what you have learned here into clinical practice can save you headaches down the road.

- Remember:

  "Your records are your best defense tool or your worst enemy"
Thanks for attending. We hope you found this course useful. Don’t forget to take Parts 2 and 3 of this series on Documentation Best Practice.