Ethics, Risk Management and Documentation

Michele Quattlebaum

- 2012, 2013, 2014, 2015, 2016, 2017 & 2018
- Texas Super Lawyer
- Board Certified Personal Injury Trial Law
  - Texas Board of Legal Specialization
- Tried chiropractic malpractice cases to verdict since ‘82
- Routinely handles board matters
- Seminars concerning chiropractic malpractice, documentation, Medicare, Ethics, Risk, and HIPAA

PI billing is not licensed to falsify

Accurate billing on PI

- Accurate coding
- Do not bill for services not rendered
- Documentation must justify
- Treatment plans must be justified
- All accidents/patients do not result in same care
- ESI can be dangerous
- HIPAA
- Insurance fraud
- Board violations

- It is YOUR responsibility to know with whom you are working
- Illegal activity will be your responsibility
- BE RESPONSIBLE
- BACK GROUND CHECKS
- AUDITS UPON REQUEST
- AGREEMENTS
  - ETHICS CLAUSES

- Keep control over signature stamps
- NPI numbers
  - Should have individual
  - When gone, no one uses your NPI
  - Notify carriers of this
- Medicare credentialing
  - Enrolled in Medicare
  - Contact Medicare when leave
- HIPAA
  - Knowledgeable about HIPAA
  - Individual NPI
  - Responsibility for billing
- Coding
  - Knowledgeable re billing/coding
  - Audit the records
  - Do not treat under another letter

- Don’t adjust when out of state
- If are with a sports team , contact state you are going to for temp license

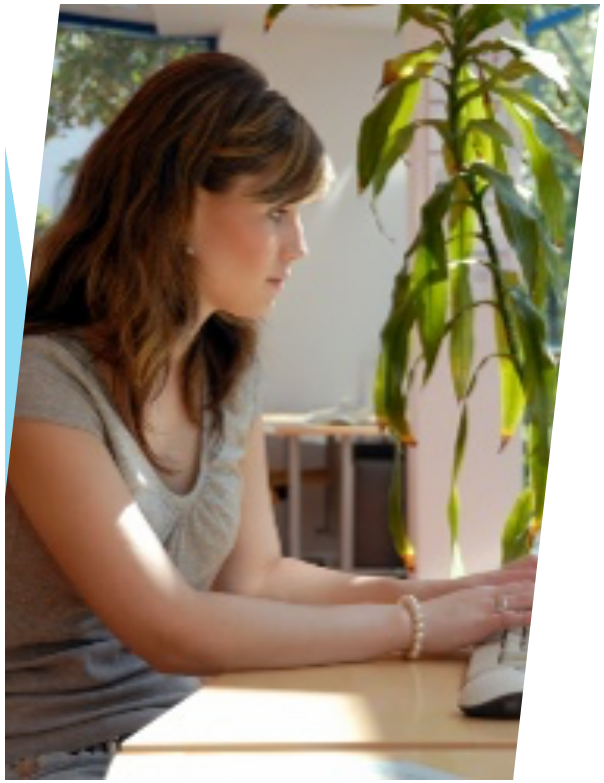
Out of state adjustments

Social Media

- Do not “friend” patients on personal page
- Be careful not to make political or controversial statements
- Doctors are held to higher standard
- HIPAA
- Advertising rules
- Scope of Practice Rules
- Enticement rules for Medicare

Patient blogging

- Caution
- ***Google yourself***
- Google & Yahoo maps reviews
- Services to cleanse



Sharing Health Information with Patients

- Blogs or Websites
- Careful to give accurate information
- Give general information
- Careful not to give specific health advice or diagnosis

Patients

- "Patient" any person who consults or is seen by a chiropractor to receive chiropractic care

- Employees
- Friends
- Relatives

Same exams, history, radiology, and record keeping

Avoiding Staff Problems pertaining to patient care

- **Hiring competent Staff**
- **Do not hire anyone you can't fire**
- **Training**
- **Confidentiality**
- **Reprimands**
- **Staff meetings**

Record Production

- Upon written authorization
- Signed by Patient
  - Personal representative if deceased
  - Parent or legal guardian, if minor
- Information to be released
- To whom they should be released
- Consent can be withdrawn

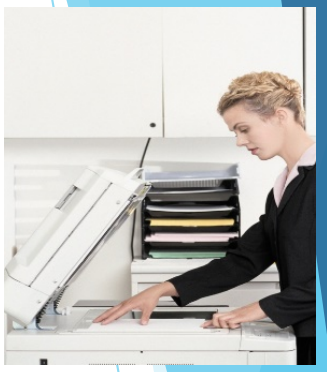
Authorization.....

- Remember the spouse can not come in and ask for records of their spouse without a written authorization. You can not discuss condition with spouse or family member.
- Children turning 18
- Without an authorization form, you can not discuss the patient with his/her attorney, even if that attorney referred patient to you.

Time to Produce

- Copies must be furnished within a reasonable time, not to exceed the days set by your board of examiners.
- Should be provided promptly
- know
- Do not have to Xerox them IMMEDIATELY while patient standing there, unless convenient

You must still produce even if..



- **Past due Account**
- **NO LOP**
- **Because you think they might sue you**
- **Because you don’t want them to go to another doctor**
- **Arguments with PI attorney**
- **Subpoena in NOT required**

Record Production

- **If you use colored inks be careful that when copying they show**
- **Make sure two sided forms are copied properly**
- **If the subpoena says “all”, it means “ALL”**
- **Do not withhold records**

Records on Disabled Patient

- If records are being requested to determine if patient is disabled you may not charge for the records.

Before charging for records

- Use common sense
- Is it going to aggravate an already dissatisfied patient

DO NOT ALTER RECORDS

- Do not alter or destroy any record that is being used in an ongoing legal proceeding or investigation, whether you or your patient is involved.

LOCUM TENENS pointers

- Check references
- Check license
- See proof of insurance or obtain temporary insurance to cover them
- Notify patients before they walk into room
- Have them adjust you
- Discuss patient charts, office procedures, record keeping
- If possible have them shadow you for a day or two before you leave your patients with them

Change of Address

- You must keep your address current with the board
- IN WRITING
- HOME and OFFICE
- EMAIL ADDRESSES TOO!!!!

- Advertising Superiority
- Must be subject to verification
- Must be within scope of practice
- No false or misleading

Print, social media, radio,
TV, articles, YouTube,
website,
Anything you put out
there,

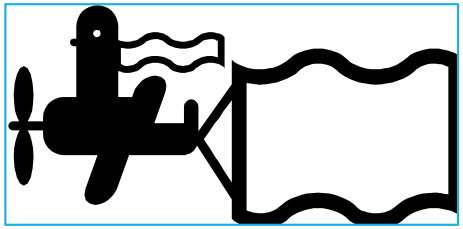
advertising……..

- Training does not change scope
- Do not advertise outside your scope
- If you identify specialty certification , must identity the board
- “diplomate”
- NO certification by NBCE

Clearly Distinguish Yourself as DC

- All advertising as DC or chiropractic
- When patient comes to your clinic they need to understand that you are a chiropractor
- Scrubs
- Facebook
- Articles
- emails

Advertising



- No false, misleading fraudulent or deceptive statements
- No statements inconsistent with practice of chiropractic
- No telemarketers who misrepresent who they are associated with
- Must keep testimonials for two years
- Signed statement that you can use testimonial
- Must distinguish chiro clinic from other business

Advertising

- If you make a claim based on research studies, you must make studies available to board or public upon request

- If you claim services are “free” you must state
  - What other component services will be conducted
  - Will those component services be free
  - Will the report of findings be free

Supervise Adequately

- Must know the qualifications
- Treatment plans
- Office/Staff Meetings
- Internal Auditing and Compliance

Hiring

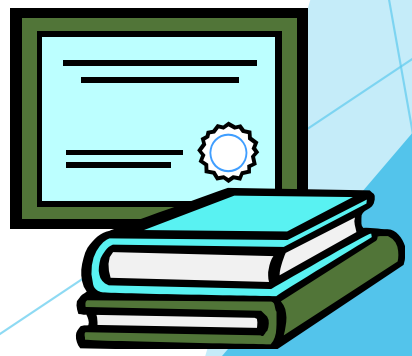
- Employees are a reflection on you
- Employers are a reflection on you
- Ask for references
- Ask other doctors who have left
- FACEBOOK
- Board record
- Lawsuit record
- Confirm insurance and license

Updating License

- Renew your license on time!!!!
- Practicing with an expired license is practicing without a license

Licensure

- Do not employ (even indirectly) a person who is not licensed or whose license is suspended or revoked
- Confirm that all working with you have a valid license



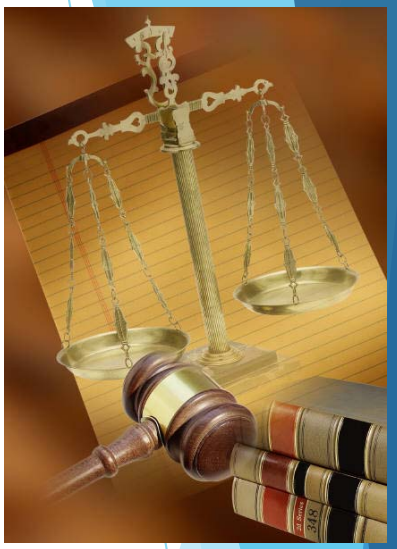
Keep License and CE Current

- **Seems basic, but many do not pay their license fee timely**
- **All professionals working with you must be licensed**
- **Make sure your associates do also!**
- **Demand Proof**
- **DO IT!**

What to do if put on Notice of Lawsuit

- Call your insurance company
- Do NOT call the patient
- Do NOT call the patient's attorney
- Don't discuss with anyone and everyone who will listen
- Do NOT post anything on facebook, twitter, etc
- Keep records, films, sign in sheets, calendar etc all safe
- Ask staff what they remember but do not have them write it down unless your attorney tells you to
- DO NOT ALTER YOUR RECORDS
- Follow advice of your attorney

Most Common Allegations In Malpractice case



- **Herniated Discs: Cervical and Lumbar (DO NOT CAUSE)**
- **Misdiagnosis**
- **Fractures**
- **CVA**
- **Failure to Refer**
- **Aggravation of Pre-Existing Condition**
- **Vicarious Liability (8%)**

When assessing a clinical situation, ask yourself the following:

- How many times have I seen this clinical presentation in the:
  - Past week…….
  - Past month…….
  - Past six months……..
  - Past year……..
- If your answer to the question is that the patient in front of you is the only one you have seen…….take a step back and reassess the situation because……

The presence of a <u>new and different headache with or without neck pain may be the only clue</u> as to the presence of an active vertebral artery dissection.

Vertebral Artery Dissection Presentation

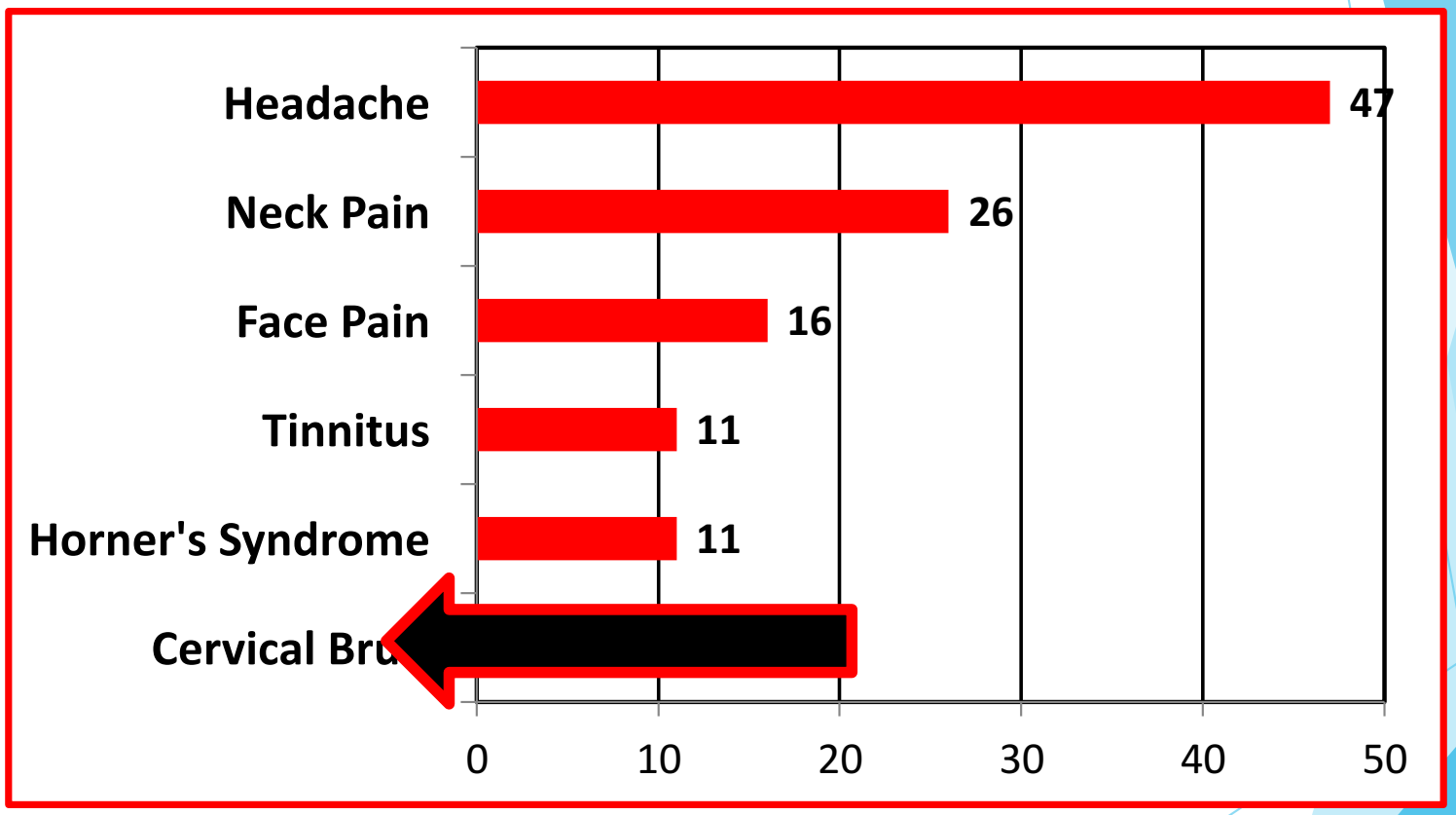
(Schievink – NEJMed)

- *50% consider headache and/or neck pain unlike any other*

- Rarely mistaken for migraine attack by those patients with a history of migraine

Cervicocephalic Arterial Dissections

Biller (Arch Neurol 1986)



Dissection Headache/Neck Pain

- Intensified by head movements – 64.3%
- Intensified by shocks – 14.3%
- Quality
  - ***Not previously experienced - 78.6%***
  - Sharp pain – 64.3%
  - Dull pain – 7.14%

High Index of Suspicion of Dissection: HEADACHE

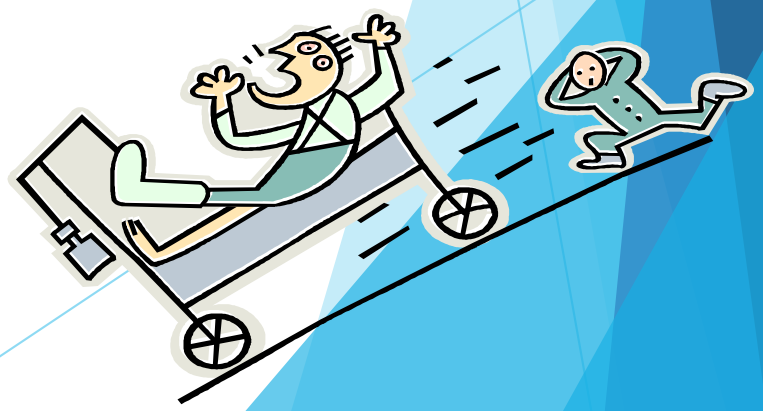
- New and different ***headache***
- Never had headache like it before
- Very severe
- Unremitting
- Unchanged by medication usage
- Possibility of other neurological signs

High Index of Suspicion of Dissection: NECK PAIN

- New and different ***neck pain***
- Unlike prior neck pain experienced
- Acute/progressive
- Unremitting/continuous
- Constrictive in quality

Patient Must Prove

- Doctor-Patient Relationship
  - Duty
- Negligence
  - What a reasonable chiropractor would NOT have done under the same or similar circumstances
- Causation
  - Direct or continual link to the negligent act
- Damages
  - Caused by the negligence



Malpractice insurance

- ❑ To have or not
- ❑ Business entity!!!
- ❑ Claims made vs Occurrence
- ❑ Limits
  - ❖ Price
  - ❖ Board matters/Medicare audit/HiPAA investigation
  - ➢ Consent vs Arbitration
- ❑ See what is covered
- ❑ Believe in Chiropractic

What other insurances?

- What other risks
- Identity theft/hipaa breach
- Worker's comp
- Slip n fall
- Disability!!!!!!!!!!!!!!!!
- Business interruption
- Auto
- Life

The buck stops with the DC

Maintaining boundaries on Social Media

- Tell patients you do not friend on your personal page, due to respect of the doctor/patient relationship
- Make sure to use extreme caution to keep highest degree of privacy settings
- You are held to a high standard of conduct
- Use restraint in your postings
- Do not discuss PHI on facebook

Closing or Transferring a Practice

- Give Notice to Patients
- Enough time for them to select another doctor
- If selling goodwill and files, go over every current file with new doctor (note chart that you did)
- Need a BAA to ensure HIPAA compliance
- Written agreement to maintain records for appropriate length of time and compliance

Closing or Transferring Practice

- Notify board
- Notify other businesses in area in case patient looking for records
- Post in newspaper
- Shred closed files
- Consider reception to introduce new doctor

Staff can Reduce Practice Risk

- Train staff to interact with patients and to handle phone calls
- Staff must take messages thoroughly and communicate them to you promptly
- Staff must involve you at first sign of a disgruntled patient
- Staff must follow confidentiality rules at all times
- Staff does not offer health care advice (even when pressed) no independent judgment

Record Retention and destruction

Know your state laws

every state law differs, make sure you know your own state's rules.

However, other record retention rules might apply

- Depending on the longest required retention policy of records you deal with

Record Destruction

- Discard Properly
- Must be HIPAA compliant
- Consider an outside vendor
- Use cross cut shredders

X-rays

- *<u>Do not ever</u> give* the patient the only copy of their x-rays to take to another doctor

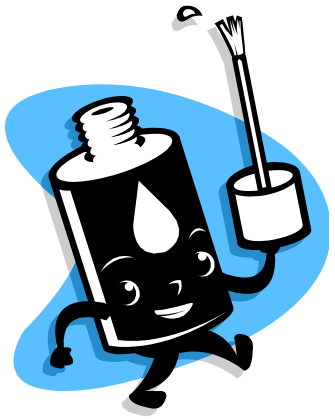
DO NOT ALTER RECORDS

- Do not alter or destroy any record that is being used in an ongoing legal proceeding or investigation, whether you or your patient is involved.

Changes can be made

- Make changes appropriately
- New page
- Date it for date change is made
- Do not black out; white out
- Do not mark exams later
- When making changes at the time doing records, one line through the error

- DO NOT change Computerized records either



Informed Consent

- Written or oral
- What a reasonable patient would want to know
- Not what the doctor wants to tell them
- Document file what you discuss with them

Informed Consent

- Must advise patient of the specific risks of the procedure
- "Material" risks must be disclosed before treatment
- "Material"
  - Inherent risks to the treatment or procedure
  - The type of risk that would influence a patient's decision

Who Can Consent

- Adults
- Incompetents- NO
- Minors---- NO, unless:
  - Active duty with US Military
  - 16 and does not live with parents and is financially independent

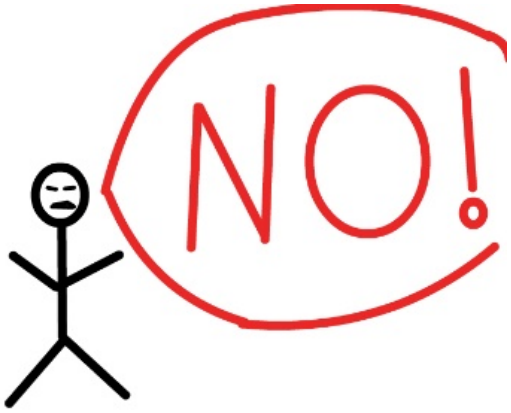
Documentation of Consent

- Written consent form
- Document chart notes that it was discussed
- Bilingual consent forms
- Illiterate patients need to have it read to them
- Disabled patients who can’t read

Documentation of Consent

- If you show video, have patient document that they watched it
- If you give patient a brochure, have patient document receipt

Informed Refusal



- Document it
- Description of treatment
- Potential benefits
- Reason denied
- Witness
- Careful decision needs to be made if will continue to treat patient

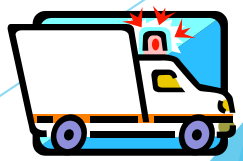
Abandonment

you may not abandon a patient without

1. reasonable cause
2. adequate notice
    1. Know if your state has a time period
3. opportunity to obtain the services or another chiropractor
4. providing for the orderly transfer of the patient records.

Dismissal of Patients without Abandonment

- **Doctor is not required to accept an individual as patient**
- **Doctor-patient relationship is necessary before abandonment occurs**
- **Abandonment occurs when:**
  - **Refusal to treat without adequate warning**
  - **Fails to respond to emergency, and patient dies**
  - **No substitute doctor when away for extended time**
  - **Failure to provide adequate follow-up care, and adverse event occurs which could have been prevented**



When to Discharge

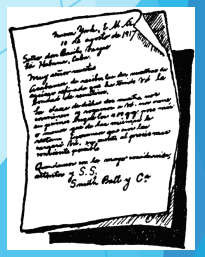
- Abusive or posing danger to others
- Substantially noncompliant
- Causes disruption in office
- Giving questionable responses to exams or treatment
- Behavior which is inconsistent with the conduct you expect from patients

How to Discharge a Patient

- Advise the patient in writing
- Advise him to seek doctor of choice or give him selection
- If not a danger or being abusive, should give notice
- If feel continued care is not indicative, no notice is necessary
- Provide patient a copy of the records and films

Written discharge

- Terminating doctor/patient relationship
- Go to a doctor of choice, if you do not have one enclosed please find a list of other practitioners
- Will provide a copy of records upon written authorization to do so



When to Refer

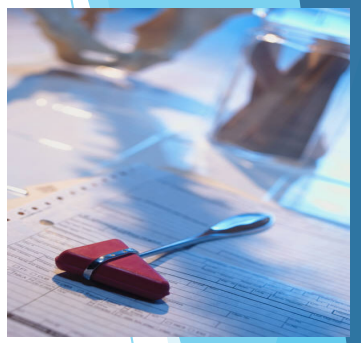
- Patient not getting better after reasonable time and sequence of treatment
- Patient worsening after reasonable time to evaluate
- Patient's condition is outside the scope of practice
- Violation of 78.2 (Proper Diligence and Efficient Practice of Chiropractic)

Referrals

- Must use care
- Who are you referring to
- Is care necessary
- What is driving the referral
  - Attorneys
  - Financial
- You are responsible for the referral
- Pain management

Documentation- first visit

- Physical exam
- Diagnosis
- Complete patient history
- Symptoms causing patient to seek treatment
- Family history if relevant
- Past health history
- Mechanism of trauma
- Quality and character of symptoms
- Onset during, intensity, frequency, location of symptoms



Documentation- Initial visit

- Aggravating or relieving factors
- Prior treatments, medication
- Secondary complaints

Subsequent visit

- Updated history
  - Review of the chief complaint(s)
  - Changes, if any, since the last visit

Examination

examination of the area involved in the diagnosis

Assessment of any change in the condition since last visit

Treatment

Documentation of treatment given

Patients response to the treatment rendered

Change in treatment plans

These documentation rules only apply to _____

ALL PATIENTS!!

Functional Improvement

- Anticipate
- Achieve
- Specific findings
- Objective measures
- If you don’t show it, will not be compensated

IMPORTANT DOCUMENTATION

- Hardship Form
- If you are going to discount services, or waive copay or deductible, you need a hardship form on file.
- Extremely important for the medicare patients

Today's Date: _____

Request for Financial Assistance

by

_____
(Patient's Name)

In as much this patient has expressed a strong and willing desire to receive care at this office, and that current circumstances exist which greatly restrict their ability to pay the practice's standard fees for services and/or any co-pays and/or deductible amounts. {*Practice Name*} agrees to temporarily waive the patient's obligation to pay that portion they would otherwise be contractually or legally bound to pay for the following services:

_____ _____

_____ _____

_____ _____

Reason for financial hardship: _____

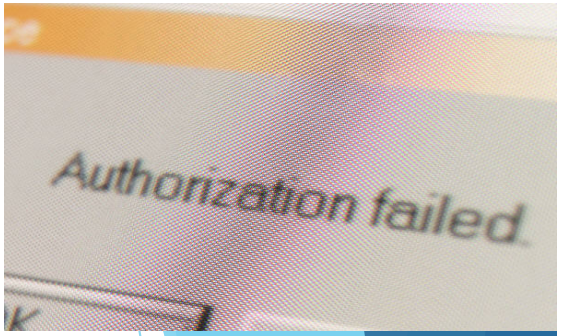
If, however, future discussion regarding their financial situation reveals that Mr./Ms. _____ circumstances have improved enough to enable them to assume a greater portion of their payment responsibility, the practice will immediately amend this agreement.

Approved by: _____ Date: _____

I understand that if my financial status or my ability to pay improves for any reason, the services rendered from that time forward will be based on the practice's 'Standard, Usual, Customary' fees.

Patient's Signature _____ Date: _____

Patient's Name _____DOB: _____ HR#_____



- **Authorizations**
  - Fax
  - Email
  - Produce records
  - Discuss with third party

- ***Documentation of Daily Charges***

Authorization to Fax/Email

I recognize that communication done electronically does not have any guarantee of privacy, however due to convenience and timing, communications might be necessary by electronic means of fax and email. I consent to communication specified below. Should I wish to withdraw the consent below I will notify the doctor/clinic in writing of the withdrawal of consent.

I, _____do hereby authorize _____ to communicate with me via fax at the following fax number_____.

_____ _____ Patient Signature

_____Patient Name

_____Date

****

I, _____do hereby authorize _____to communicate with me via email at the following email address_____.

_____ _____ Patient Signature

_____Patient Name

_____Date

Clinical forms (mandatory)

- Consent to Treat
- Consent to Treat a Minor Child (patient signature required)
- Non pregnant information (for x-rays)

- Exam
- Diagnosis
- Daily notes
- Treatment Plan
- X-Ray Report
- Daily Progress Forms (for patient to fill out)

Clinical forms (mandatory)

Initial History Form

- Patient must complete form before the doctor sees the patient
- Front Desk responsible
- Thorough answers
- REVIEW IT!

Computerized Notes

- Must be accurate
- Done timely
- Not SAME OLE SAME OLE

You should document

- Use of more complicated codes
- Non compliance
- Referrals (whether patient goes or not)
- Consistent abbreviations
- Legible writing
- Timely

Written Treatment Plans

TREATMENT PLANS MUST INCLUDE

- Treatment goals
- Objective measures
- Recommended levels of care
  - Frequency
  - Duration

Must be in writing and not just oral

Sample Treatment Plan

Make sure your treatment plan contains the documentation requirements

Available on nacatexas website

TREATMENT PLAN

PATIENT: _____ **DATE:** _____

_____ INITIAL PLAN ____ SUBSEQUENT PLAN *(Phase of Care_____)* Date of onset: _____

DIAGNOSIS: 1._____ **2.**_____ **3.**_____ **4.**_____ **5.**_____ **6.**_____ **7.**_____ **8.**____ **9.**_____ **10.** _____
DAILY ACTIVITIES DISRUPTED: _____
_____

TREATMENT:

Adjust (98940-3): Regions C 1 2 3 4 5 6 7 T 1 2 3 4 5 6 7 8 9 10 11 12 L 1 2 3 4 5 S__ P__ ___ Xs ___
Frequency and Duration

To Diagnosis: 1 2 3 4 5 6 7 8 9 10 *(circle appropriate corresponding diagnosis from above)*

Specific extremity region: _____
rib, knee, ankle, wrist, shoulder etc.

PHYSICAL MEDICINE:	**Diagnosis:**	**Time:**	**Setting:**	**Description of 97110, 97112, 97140, or 97530 Rationale**
1.				
2.				
3.				
4.				

Frequency and Duration: Mon. Tues. Wed. Thurs. Fri. Sat. "**Xs**" 1 2 3 4 weeks

Complicating Factors:_____
Supplies given to the patient: _____
Diagnostic Tests Recommended:_____
Medical Records Requested From:_____

GOALS:
Patient presented with _____ Pain Level. Anticipated Pain Level _____ in _____ weeks.
Measures used to Evaluate Treatment Effectiveness:_____
Patient presented with a _____ Range of Motion. Anticipated Range of Motion _____ in _____ weeks.
Measures used to Evaluate Treatment Effectiveness:_____
Score for the neck or back _____ index _____. Anticipated Score _____ in _____ weeks.
Disability Index used to Evaluate Treatment Effectiveness.

Next Re-Evaluation: _____ **Anticipated Release Date:** _____

Treating Doctor: _____**Date:** _____
Print Doctor Name here

_____ **Date:** _____
Patient's Signature

Clinic name address and phone

List all codes and symptom diagnosis

DAD – unable to bend over to tie shoes, not sleeping, needs assistance to walk

Circle what you will adjust and how many times a week for how many weeks

Circle days of the week and for how many weeks

TREATMENT PLAN

PATIENT: _____ **DATE:** _____

_____ INITIAL PLAN ____ SUBSEQUENT PLAN *(Phase of Care_____)* Date of onset: _____

DIAGNOSIS: 1._____ 2._____ 3._____ 4._____ 5._____ 6._____ 7._____ 8.____ 9._____ 10. _____
DAILY ACTIVITIES DISRUPTED: _____
_____

TREATMENT:

Adjust (98940-3): Regions C 1 2 3 4 5 6 7 T 1 2 3 4 5 6 7 8 9 10 11 12 L 1 2 3 4 5 S__ P__ ___ Xs ___
Frequency and Duration

To Diagnosis: 1 2 3 4 5 6 7 8 9 10 *(circle appropriate corresponding diagnosis from above)*

Specific extremity region: _____
rib, knee, ankle, wrist, shoulder etc.

PHYSICAL MEDICINE:	**Diagnosis:**	**Time:**	**Setting:**	**Description of 97110, 97112, 97140, or 97530 Rationale**
1._____				
2._____ **Ultrasound**	**2 & 4**	**15m**	**40mhz**	**reduce edema**
3._____				
4._____				

Frequency and Duration: Mon. Tues. Wed. Thurs. Fri. Sat. **"Xs"** 1 2 3 4 weeks

TREATMENT PLAN

List factors that may complicate the patients recovery time

Complicating Factors:_____
Supplies given to the patient: _____
Diagnostic Tests Recommended:_____
Medical Records Requested From:_____

MUST list Measures Used to Evaluate Treatment Effectiveness

GOALS:
Patient presented with _____ Pain Level. Anticipated Pain Level _____ in _____ weeks.
Measures used to Evaluate Treatment Effectiveness:_____
Patient presented with a _____ Range of Motion. Anticipated Range of Motion _____ in _____ weeks.
Measures used to Evaluate Treatment Effectiveness:_____
Score for the neck or back _____ index _____. Anticipated Score _____ in _____ weeks.
Disability Index used to Evaluate Treatment Effectiveness.

Next Re-Evaluation: _____ **Anticipated Release Date:** _____

Treating Doctor: _____ **Date:** _____
Print Doctor Name here

_____ **Date:** _____
Patient's Signature

Clinic name address and phone

Coding

- Do NOT UPCODE
  - Billing a more complex and higher paid service than the one documented in the medical record
- Do NOT MISCODE
  - Bill for one service which is covered instead of the service you performed which is not

Upcoding

- Can be HIPAA Violation
- Does not meet Medicare guidelines when records indicated a problem in one area of the spine which was examined, but treatment to several areas of spine
- Abuse of 98942 was greater than 80%
- 7% of billings have no documentation

Common Record Keeping Mistakes

- Not documenting phone calls
- Charting only the abnormal
- Entries not signed
- Failure to document noncompliance
- Test results that do not have a clinical rationale, evidence of review by the doctor
- Failure to notify patient
- Insufficient information regarding home care

Common Record Keeping Mistakes

- No note regarding informed consent
- No note regarding visiting doctor
- No documentation of patient education
- Failure to perform follow up exams
- Use of subjective language rather than objective
- Critical remarks about other providers
- Egotistical remarks

- Contraindications to certain procedures or therapies buried in the record
- Records that don't change over a series of office visits
- Computer records that do not vary
- Making patients sicker than they are

Common Recordkeeping Mistakes

MUSCULOSKELETAL EXAMINATION

CMS DOCUMENTATION REQUIREMENT

Level of Exam	Perform and Document
Problem Focused 99201/99212	**One** to **five** elements identified by a bullet
Expanded Problem Focused 99202/99213	At least **six** elements identified by a bullet
Detailed 99203/99214	At least **twelve** elements identified by a bullet
Comprehensive 99204/99205/99215	Perform **all** elements identified by a bullet; document every element in each box with a shaded boarder and at least **one** element in each box with an unshaded border.

REQUIREMENT
MUSCULOSKELETAL EXAMINATION

Constitutional

- Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)
- General appearance of patient (eg, development, nutrition, body habits, deformities, attention to grooming)

Cardiovascular

- Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)

Lymphatic

- Palpation of lymph nodes in neck, axillae, groin and/or [illegible]tion

MUSCULOSKELETAL EXAMINATION

CMS DOCUMENTATION REQUIREMENT

Musculoskeletal

- Examination of gait and station

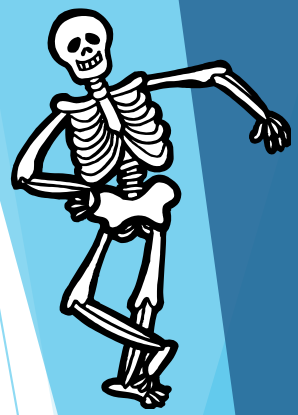
Examination of joint(s), bone(s) and muscle(s)/tendon(s) of four of the following six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes:

- Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
- Assessment of range of motion with notation of any pain (eg, straight leg raising), crepitation or contracture
- Assessment of stability with notation of any dislocation (luxation), subluxation or laxity
- Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements

NOTE: For all the comprehensive level, the examination of all four anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities constitutes two elements.

MUSCULOSKELETAL EXAMINATION

CMS DOCUMENTATION REQUIREMENT



Extremities [See musculoskeletal and skin]

Skin

- Inspection and/or palpation of skin and subcutaneous tissue (eg, scars, rashes, lesions, cafe-au-lait spots, ulcers) in four of the following six areas: 1) head and neck; 2) trunk; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity.

NOTE: For the comprehensive level, the examination of all four anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities constitutes two elements.

MUSCULOSKELETAL EXAMINATION

CMS DOCUMENTATION REQUIREMENT

Neurological/ Psychiatric

- Test coordination (eg, finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)
- Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (eg, Babinski)
- Examination of sensation (eg, by touch, pin, vibration, proprioception)
- Orientation to time, place and person
- Mood and affect (eg, depression, anxiety, agitation)

MUSCULOSKELETAL EXAMINATION

CMS DOCUMENTATION REQUIREMENT

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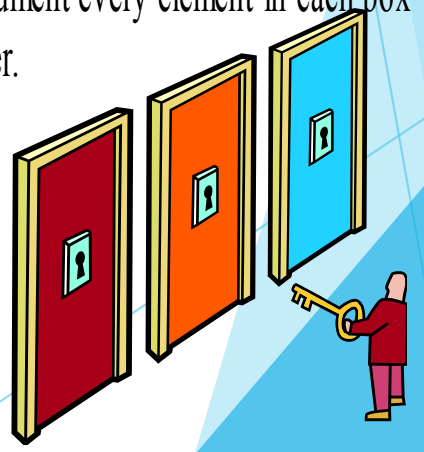

Questions