7 Steps to Perfect Case Management
Protect Your Patients & Your Practice

The Rules of the Game Have Changed

7 Steps To Systematic Case Management
1. PE: Physical Examination Findings
2. FCE: Functional Capacities Evaluation
3. OATS: Outcome Assessment Tools
4. GOALS: Short & Long Term
5. Documentation
6. Correct Coding: ICD-9 & CPT™
7. Treatment Plan

Step 1: The Physical Examination

Be Data Driven
- An insurance adjuster must be able to see what you see with the patient.
- Include measurements, comparison data, test results, co-morbidity, unusual circumstances to paint a picture of what’s going on with the patient.
- In order to document your outcomes you must first decide which outcomes to track!

A Round Hole & A Square Peg
**Step 2: Functional Capacities Evaluation**

When To Perform Functional Tests
- Performed as soon as the patient is out of the acute pain phase of care.
- This is when the goal of care transitions from pain relief to functional restoration.
- Should include a battery of tests, which are safe, inexpensive, time efficient, reliable, and comparable to normative databases.

Doctor & Patient Motivation
- Identifies the patient’s “weak link”.
- If a patient is less than 85% of normal for any specific test, then rehab training is required.
- Provides unmistakable evidence that the patient’s condition may be due to factors in the patient’s and not the doctor’s control.

Dynamic Strength & Endurance Tests

Endurance
Physical Performance Testing

- "Valid, reliable, safe, practical, and responsive measures of trunk strength and endurance."
- **4 Tests**
  - Repetitive Sit-up
  - Repetitive Arch-up
  - Repetitive Squatting
  - Static Back Endurance

Functional Test Procedures

- Repetitive Sit-ups - Arch-ups - Squatting
  - 50 reps maximum
  - 2-3 seconds per repetition
  - "If the motion becomes clearly jerky or asymmetrical, the test should be stopped"
- Static Back Endurance
  - 240 seconds maximum
  - "Test discontinued if aggravated by pain or muscle spasm."

Functional Test Guidelines

- Patient warm-up for 5 minutes prior to beginning testing (bicycle/ergometer)
- Tests are retested in the same order
- 1-minute interval between each test
- Tester may count repetitions aloud but should remain as neutral as possible
- Test terminated if patient told more than one time to correct trunk motion
- Patient informed about mild painful feelings in tested muscle groups during the couple of days following the maximal test.

Balance & Coordination Tests

One Leg Stand

- The doctor is near the patient.
- The patient stands on one leg; nonsupport leg is bent 60 degrees at the hip and 90 degrees at the knee so that the ankle is at the height of the support leg’s knee.
- The patient maintains the position as long as possible.
- Time the duration the position can be held, i.e., until the patient moves the support foot, puts other foot down, or reaches out to grasp with the hand(s).

### One Leg Stand

<table>
<thead>
<tr>
<th>AGE (years)</th>
<th>EYES OPEN (seconds)</th>
<th>EYES CLOSED (seconds)</th>
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<tbody>
<tr>
<td>20-59</td>
<td>29-30</td>
<td>21-28.8</td>
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<tr>
<td>60-69</td>
<td>22.5</td>
<td>10</td>
</tr>
<tr>
<td>70-79</td>
<td>14.2</td>
<td>4.3</td>
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Range of Motion Testing

Global Range of Motion

<table>
<thead>
<tr>
<th>Region</th>
<th>ROM</th>
<th>Global</th>
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<tbody>
<tr>
<td>Cervical</td>
<td>F + E + L/R LF + Rot</td>
<td>385 deg.</td>
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<tr>
<td>Th-Lumbar</td>
<td>F + E + L/R LF</td>
<td>175 deg.</td>
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</table>

Flexor : Extensor Ratio Testing

The Flexor/Extensor Ratio

- The extensors muscles of the lower back should be approximately 30% stronger than the flexors.
- This ratio is 1 to 1.3.
- The extensors muscles of the neck should be approximately 40% stronger than the flexors.
- This ratio is 1 to 1.4.
- This is called the Flexor/Extensor Ratio.

Recurrence & Chronicity

- If the flexors and extensors are not in the proper ratio and a patient is given exercises to strengthen both the flexors and extensors in equal proportion, the exercise will reinforce this dysfunction.
- The literature states that a patient with a reversal of the normal Flexor:Extensor Ratio has a much greater likelihood of recurrence and chronicity.
- For this reason, the Flexor: Extensor Ratio must be addressed prior to exercise.

Coding For Functional Testing
Functional Testing

- Manual Muscle Testing 95831
- Range Of Motion 95851
- Physical Performance Testing 97750
- Normally these services are included in the E/M code.
- The E/M code can be adjusted upward to account for the added work with the patient.

Independent Billing Requirements

- According to the ACA, under the following circumstances, functional testing codes can be billed independent from E/M services.
- Testing and measurements are taken and compared to a standardized grading scale.
- A formal written and signed report of the findings is made including the comparison analysis.

Range of Motion Template Reports

- Reports should indicate whether the motion is passive or active
- Document location and any pain or symptoms with motion


- Grade muscle strength on a 0-5 scale.
- Isolate muscle groups vs. specific muscles to determine the neurology involved.

Outcome Assessment Tools

- Outcome tools can be used to aid you when setting goals for your patients care.
- These tools provide measures to evaluate the patients ability to function with everyday activities of daily living.
Revised Oswestry Questionnaire

- 10 categories: Pain Intensity, Personal Care, Lifting, Walking, Sitting, Standing, Sleeping, Social Life, Traveling, and Pain
- Total possible score is 50 points.
- Expressed as a percentage of 100.

Bournemouth Questionnaires

- Works under the assumption that neck and back pain are lifestyle illnesses, rather than "diseases."
- Contains 7 core items: Pain Intensity, Disability in ADLs, Social Activities, Anxiety, Depression, Fear Avoidance, & Locus Of Control.

Outcome Assessment Forms

- Foundation for Chiropractic Education and Research (FCER)
- 1-800-622-6309
- Copyright permission.
- FREE 30-day Trial Offer pay only $15 shipping and handling charge.
- If you wish to continue, purchase at that time.
**Step 4: Goal Writing**

**Functional Goal Setting**
- In a wellness-based model of care, the goal is much more than symptomatic improvement.
- The goal is patient wellness, optimal health, fitness and full functional capacity.
- Outcome Assessment Questionnaires are an important component in setting functional goals for your patients.

**How To Write A Goal**
- Increased Tolerance to...
- Return to Normal...
- Name ADL...
- For a Duration of Time...
- By When.
- “Increased tolerance to sitting for up to 60 minutes within the next 4 weeks.”

**Step 5: Correct Coding**

**Writing A Diagnosis**
- The diagnosis that you choose to represent your patients’ conditions directly relates to the level of care permitted by third-party payers.
- You should structure your diagnoses so that you accurately represent patients’ clinical presentations on the insurance claim form.
Insurance Form Overview

- CMS 1500 is the uniform, standardized form used by providers and accepted by public and private payers to report billings.
- Download the form and instructions at: http://cms.hhs.gov/providers/edi/1500info.asp
- The ACA’s Coding Solutions Manual has the best explanation on how to use this form.

Diagnostic Descriptors

- In the past, your diagnostic descriptors may not have ventured beyond the diagnoses of subluxation or segmental dysfunction.
- Including subluxation in your diagnosis is a requirement for Medicare reimbursement.
- Limiting your diagnoses to only these descriptors is insufficient for a patient to receive insurance support for chiropractic care and a program of rehabilitative exercises from other third-party payors.

A Tissue Specific Diagnosis

- It is helpful to structure your diagnoses based upon the specific tissues that are involved in the patient’s condition.
- When you review an insurance claim form, you will notice that space has been provided for four diagnostic descriptors.
- Be sure to use all of the appropriate diagnostic descriptors that accurately represent your patients’ conditions.

Four Spaces

- Always include all appropriate descriptors (ICD-9 codes) in your diagnoses.
- Patients may have more than four diagnostic descriptors that describe their condition.
- The powers that be have decided that 4 is all they want to see on a claim form.
- Note any additional descriptors in your documentation.

Documenting Diagnoses

- When 4 spaces isn’t enough...
- Note any additional descriptors in your written documentation.

Radiculitis
Cervical Disc Degeneration
Restricted Motion
Myalgia
Subluxation
Cervicalgia
Cervical Brachial Syndrome
Paresthesia

The Hierarchy of Coding

- There is a hierarchy that you should follow in reporting these diagnostic descriptors.
- A neurological descriptor, only when present, should always be located in the first position.
- In the second position, place any structural descriptors.
- Functional descriptors should be placed in the third position, and in the final position, place Soft tissue, Extremity, or other descriptors.
The Hierarchy

- Neurological Diagnosis
- Structural Diagnosis
- Functional Diagnosis
- Soft Tissue, Extremity, Catch All Diagnosis

CMS 1500 Box 21

<table>
<thead>
<tr>
<th>Position</th>
<th>Category</th>
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<tbody>
<tr>
<td>1</td>
<td>Neurological</td>
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<tr>
<td>2</td>
<td>Structural</td>
</tr>
<tr>
<td>3</td>
<td>Functional</td>
</tr>
<tr>
<td>4</td>
<td>Soft Tissue, Extremity, Catch-All</td>
</tr>
</tbody>
</table>

International Classification Of Diseases Codes (ICD-CM)

- ICD-CM codes tell the computer what is wrong with your patient.
- When you submit a CMS 1500 form, you trigger a computer database to allow a programmed level of care.
- Be sure your ICD-CM codes and CPT™ codes are compatible and linked - this will help you establish the medical necessity of your care.

Linking Diagnoses

- You must link CPT™ codes to the appropriate diagnosis codes in Box 21.
- Box 21: "Relate items 1, 2, 3 or 4 to Item 24E by line."
- If your billing software automatically defaults to diagnoses 1-4, contact your software vendor to unlock this feature.

International Classification Of Diseases Codes (IDC-CM)

- Always carry ICD-CM codes to the 4th or 5th digit if it is available. The 5th digit makes the code more specific.
- Carry the code out to every digit beyond the decimal point. For example, if a code ends in zero or 10, always include the zero.
- Don’t code with non-specific or non-classified codes.

Position 1 Neurological

- When a patient has a neurological component to his or her diagnosis, place it in the first position.
- A neurological diagnosis must be supported by objective signs and symptoms in your written documentation.
- Examples of neurological diagnoses include Sciatic Neuritis 724.3 & Lumbar Radiculitis 724.4
Position 2 Structural
• A structural diagnosis involves the anatomical structures of the spine.
• This includes the vertebrae and discs.
• Examples of structural diagnoses for the spine include Cervical Disc Degeneration 722.4, Idiopathic Scoliosis 373.30, & Spondylolisthesis 738.4

Position 3 Function
• It is important to include function in your diagnosis when you are including Active Care / Therapeutic Procedures / Rehab Exercises in your treatment plan.
• You must learn to speak the language of function and this means objectively measure and document functional outcomes.
• Functional diagnoses include Restricted Range of Motion 719.58, & Deconditioning Syndrome 728.2.

Position 4 Soft Tissue
• If your plan of care includes any type of treatment involving the soft tissues, you must include a soft tissue diagnosis.
• This includes Manual Therapy 97140 and Massage Therapy 97124.
• If the patient has muscle pain, Myalgia 729.1 is excellent to support Manual Therapy.

Position 4 Extremity Diagnosis
• If your plan of care includes the chiropractic extremity adjustment, 98943, you must include an extremity diagnosis.
• Extremity diagnoses can be placed in the forth position if it is not occupied by a soft tissue diagnosis.
• Examples of extremity diagnoses include Frozen Shoulder 717.1 & TMJ Disorder 534.63

Position 4 Catch-All
• The fourth and final position can serve as a catch-all location for any other diagnosis that is descriptive of your patient’s condition.
• This includes diagnoses such as Headache 307.81, or Pain Syndromes, such as Sacroiliac Pain 724.6.

CMS 1500 Box 21

<table>
<thead>
<tr>
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<th>Neurological</th>
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</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>2</td>
<td></td>
<td>Soft Tissue Extremity Catch-All</td>
</tr>
</tbody>
</table>

10
**Updating Diagnoses**

- As your patients progress through and respond to your care, their symptomatology should improve.
- Re-evaluate the patient’s condition periodically (every 12 visits or 30 days) and update the diagnosis.
- What occurs when a diagnosis drops out – if, for example, the patient no longer has neurological symptoms?

**CMS 1500 Box 21**

<table>
<thead>
<tr>
<th>1</th>
<th>Neurological</th>
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<tr>
<td>2</td>
<td>Structural</td>
<td>4</td>
<td>Soft Tissue Extremity Catch-All</td>
</tr>
</tbody>
</table>

**Multiple Neuro Dx**

- If a patient has multiple neurological diagnoses, list them first.
- For example, if a patient has both a cervical and a lumbar radiculitis, use Radiculitis Cervical Spine, in the first position, and Radiculitis Lumbar Spine, in the second position.
- The third position becomes the Structural and the fourth position the Functional diagnosis.
- Never use a neurological diagnosis unless it’s clinically supported.

**CMS 1500 Box 21**

<table>
<thead>
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<th>1</th>
<th>Neurological 1</th>
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<tr>
<td>2</td>
<td>Structural</td>
<td>4</td>
<td>Soft Tissue Extremity Catch-All</td>
</tr>
</tbody>
</table>

**Subluxation**

- It is important to include the diagnosis of subluxation when delivering chiropractic care.
- However, other diagnostic descriptors are interpreted by third party payors to carry greater reimbursement value and should be placed above subluxation in the limited space provided on the insurance claim form.
- Maintain the diagnosis of subluxation in your documentation, until other diagnoses drop out and you have room on the form.
Exception to the Rule

- Medicare may require subluxation in the first position.
- In this case, all other descriptors will shift down one position.
- In order to provide justification for a 3- or 5-area CMT, you must follow the P.A.R.T. process to document all areas adjusted.
- Medicare does not require a diagnosis of subluxation for each area on the claim form.
- Check with your local Medicare Carrier for regulations in your State.

Medicare Exception

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Neurological</td>
<td>Functional</td>
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</tbody>
</table>

Check with your local Medicare Carrier

Master Diagnosis Sheet

Clinical Documentation Is Key

- Using the correct code alone is not always sufficient.
- Careful clinical documentation is required and may be requested by the payer.
- Lack of clinical documentation is the number one reason for denial of service by payers.
- Most insurers live by the claim handling rule: "If it wasn’t written down it wasn’t done."

CPT™ Codes

Integrity

- The quality or state of being of sound moral principle; uprightness, honesty, sincerity
- Accordance with the relevant moral values, norms and rules
- Honesty; sincerity; trustworthiness
No Where To Hide

- Cash-only practice or not accepting Medicare is no excuse for sloppy records.
- Every practice must maintain records that reveal proper care and decision making.
- Not according to your definition but the established standard of care for your profession.

CPT Procedure Codes

- There are over 7,500 CPT codes.
- We use only 25-30 codes the majority of the time.
- The CPT codes you use must describe the services you perform and be within your scope of practice.

CMT Codes Review

CMT Codes

98940-3 the basic building blocks and best description of the DC's work.
Most comprehensive physician code to describe chiropractic services.
Basic service around which everything else is built.

3 Spinal CMT Codes

- 98940: One to two spinal regions
- 98941: Three to four spinal regions
- 98942: Five spinal regions

Coding The CMT

- According to CMS:
  - 98940: 35%
  - 98941: 55%
  - 98942: 10%
- Full Spine Adjustment: The treating doctor should prioritize the level of adjustment and code for the primary area(s) of concern.
Five Extraspinal Regions

- 98943- Extraspinal Manipulation
- Head (including TMJ, excluding atlanto-occipital region)
- Lower Extremities
- Upper Extremities
- Rib Cage (excluding costotransverse and costovertebral joints)
- Abdomen!

Rule For 51 Modifier

- Until January 2006, DCs were told that they must always use the 51 Modifier whenever they billed for an extremity adjustment (98943) on the same visit as a spinal adjustment (98940–42).
- This is no longer the case.
- The 51 Modifier is not needed after the extremity CMT code 98943.
- Previously, using the 51 Modifier after the extremity CMT allowed the carrier to “discount” the second (multiple) procedure by 50%.

Linking Diagnoses

- Indicate separate areas on an insurance claim form by linking each procedure to a diagnosis referring to a different area.
- If your billing software automatically defaults to diagnoses 1-4, contact your software vendor to unlock this feature.

Therapeutic Procedures

Breakthrough Coaching

Active Care

- Therapeutic Procedures are time-based codes.
- Billed in 15-minute units beginning with 8 minutes.
- The patient is active in the encounter.
- Require direct one-on-one patient contact by provider of the service.

97110 Therapeutic Exercises

- Develop one functional parameter: strength, endurance, range of motion, or flexibility
- Treadmill for endurance
- Isokinetic exercise for ROM
- Lumbar stabilization exercises for flexibility
- Stability ball to stretch or strengthen
97112 Neuromuscular Re-education
- Used to describe those activities that affect proprioception
- Balance
- Coordination
- Kinesthetic sense
- Posture

97530 Therapeutic Activities
- Used when multiple parameters are trained including balance, strength, and range of motion.
- Must be related to a functional activity with direct functional improvement expected.
- Use Outcomes Assessment Tools.

97124 Massage
- Massage is a passive procedure used for restorative effect.
- Used for effleurage, petrissage, and/or tapotement, stroking, compression, and/or percussion.
- An independent procedure from CMT and is considered separate and distinct.

Peak Performance VHS/DVD
- Movement Pattern Analysis
- Post-Isometric Relaxation
- Neuromuscular Re-education
- Bonus Exercises
- Price $79 by mail $49 today.

Proper Use of Timed Treatment Codes
Compliant Coding

Counting Timed Units
- There are two methods of reporting timed codes.
- The 15-minute (CPT) Rule
- The 8-minute (Medicare) Rule.
- Some carriers prefer one over the other for consistency sake...and, of course, if we ever get full-scope coverage under Medicare, the 8 minute rule will apply there.
- Our advice is to pick one and stick with it consistently, unless directed otherwise by a payer.
Defining Pre- and Post-Service Time

- The guidelines restrict therapists from counting pre- and post-delivery service time.
- Report only the time spent in actual delivery of a therapeutic procedure.
- Exclude rest time, bathroom breaks, etc.

Document Actual Time

- CMS says that therapists should document the beginning and ending time of treatment in the clinical record.
- Therapists should document the start and stop time of each treatment modality — or the beginning and ending time of the treatment.
- Does this mean you must use a stop watch?? Of course not!
- Be diligent in listing appropriate time in your documentation of timed codes.

Counting Units

Single CPT® Codes

- For the first unit of a time-based code to be reported, you must perform at least 8 minutes.
- It’s important to understand this is for a SINGLE CPT® CODE.
- Multiple services are counted differently.
- This is explained later in this presentation.

Multiple CPT® Codes

- If more than one CPT® code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time.
- We’ll illustrate on the following examples exactly how this is to be counted.

Example 1: Multiple CPT® Codes

- A patient receives 8 min. of Manual Therapy, 97140; 17 min. of Kinetic Activities, 97530; and 10 min. of Therapeutic Exercises, 97110.
- The total therapy time is 35 minutes.
- Only two units of therapy time may be billed, despite the fact that three distinct services were performed, because the 38 minute threshold wasn’t reached.

Total 35
Pop Quiz: Which Codes Are Billed?

- We know we did 35 minutes of total time.
- This falls into the "2 Unit" parameter.
- Because Therapeutic Exercise and Kinetic Activities were the longest total time, we bill one unit of 97110 and one unit of 97530.

Less Than 8 Minutes

- In consideration of the 8 minute rule, you have time ranges that constitute units and multiple units (i.e. 8-22 minutes=one unit, 23-37 minutes=2 units)
- Anything less than 8 minutes does not constitute a unit and is not reportable at all.
- If the 8 minute rule is being used, a -52 should not ever be used.

52 Reduced Services

- The 15 minute rule is quite the opposite. If anything less than 15 minutes of a service is provided, the code should be appended with a 52 to signify that less than the full service was rendered.
- Bill your normal fees for this service and document the record.
- If you did only 6 minutes of Myofascial Release or Trigger Point Therapy to a different body region in conjunction with a CMT, code the reduced services as 97140-52.

CPT® Modifiers

- 25: Separately Identifiable Procedure
- 52: Reduced Services
- 59: Distinct Procedural Service
- 76: Repeat Procedure by Same Physician

25 Separate E&M Procedure

- The 25 modifier means "separately identifiable evaluation and management service by the same physician on the day of a procedure or service."
- The 25 modifier is used whenever a procedure, such as physical therapy, is performed on the same day as a re-exam.
- Adding a 25 modifier to your 99211-4 re-exams to stop bundling.
### 52 Reduced Service
- When a procedure or service isn’t completed to its full extent, report it as a reduced service.
- If you perform less than one 8-23 minute unit of a timed modality, add a 52 modifier to indicate that a reduced service was performed.

<table>
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<tbody>
<tr>
<td>99213</td>
<td>25</td>
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<tr>
<td>98940</td>
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</table>

### 59 Separate Procedure
- 59 is an important modifier; it is used to keep the insurance company from bundling procedure codes.
- It should be used whenever you bill manual therapy, 97140, together with a chiropractic adjustment, 9894X.
- 59 indicates a distinct procedure was performed.
- When 9894X and 97140 are billed on the same day, they must be performed on separate areas of the body, i.e. neck and lower back.

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
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<tr>
<td>97110</td>
<td>52</td>
</tr>
<tr>
<td>98940</td>
<td></td>
</tr>
</tbody>
</table>

### 76 Second Procedure
- The 76 modifier is used to report “a second procedure, which has been previously reported or performed on the same day.”
- This modifier is used when a patient was seen in the morning and needed to come back in the afternoon for more care.

<table>
<thead>
<tr>
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<th>MODIFIER</th>
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<tr>
<td>97140</td>
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**CMS 1500 Form**

<table>
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<th>PROCEDURES, SERVICES OR SUPPLIES</th>
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<td>(Explain Unusual Circumstances)</td>
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<td>98940</td>
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**Code Misuse**

- Is serious and must be avoided - share this message with your peers.
- Create a “safe harbor” within your practice with a commitment to correct coding.
- The Health Insurance Association of America’s 1999 Fraud Survey reported a 4% incidence of DC fraud.
- Let’s keep it low and try to eliminate it altogether!

**Step 6: Documentation**

**The RAND Study**

- RAND studied the appropriateness of DCs’ decisions to use spinal manipulation to treat low back pain.
- A review of office records was combined with ratings from a panel of DC and MD experts and reinforced with a literature review.

**The RAND Study**

- Chiropractic decisions to use spinal manipulation were deemed appropriate 46% of the time.
- Decisions were judged inappropriate 29% of the time. Researchers say this should be reduced!
- The remaining 25% appropriateness was uncertain.

**SOAP Note Template**
Step 7: Writing A Treatment Plan

Putting It All Together
1. PE: It all begins with your exam
2. FCE: Objective, quantifiable data
3. OATS: ID activity tolerances & psychosocial factors
4. GOALS: Clear, objective benchmarks
5. Documentation: “If it isn’t written down, it doesn’t exist.”
6. Correct Coding: Paint a picture of the patient’s condition with numbers
7. Treatment Plan: Realistic endpoint for care

The Other RAND Study
- A 3-year investigation of the value of chiropractic care in people 75 years plus.
- Those under chiropractic care had better overall health and a higher quality of life.
- The chiropractic users were less likely to have been hospitalized and to have used a nursing home, had fewer chronic conditions, were more likely to exercise vigorously and to be mobile, and less likely to use prescription drugs.

www.mybreakthrough.com

Therapy Treatment Plan Template