Who does Money Tree Billing, LLC turn to for the latest in Medicare compliance information? Ron Short, DC, MCS-P, Heartland Consulting Group, is a certified insurance consultant, certified peer review specialist, and certified medical compliance specialist. Dr. Short is one of the first of a new breed of chiropractic consultants; a chiropractor with practice experience trained and certified to address and solve compliance problems. He has received ChiroCode Institute’s highest recommendation as a consultant and speaker. Following is a summary of a recent webinar presented by Dr. Short on PQRS. We’ve compiled a summary of the most important details you need to know.

Measure #131 Pain Assessment and Follow-up
(Pick ONLY one of the following “G” codes EVERY daily visit)

OPTION 1:
*PAIN ASSESSMENT DOCUMENTED AS POSITIVE AND FOLLOW-UP PLAN DOCUMENTED:

G8730: Pain assessment documented as positive utilizing a standardized tool AND a follow-up plan is documented.

OR

G8731: Pain assessment documented as negative, no follow-up plan required.

OPTION 2:
*PATIENT NOT ELIGIBLE FOR PAIN ASSESSMENT FOR DOCUMENTED REASONS:

G8442: Documentation that patient is not eligible for a pain assessment.

OR

G8939: Pain assessment documented, follow-up plan not documented, patient no eligible/appropriate

OPTION 3:
*PAIN ASSESSMENT NOT DOCUMENTED –REASON NOT GIVEN

G8732: NO documentation of pain assessment - reason not given

OR

G8509: Documentation of positive pain assessment: NO documentation of follow-up plan, reason not given

Measure #131

- This measure documents the use of standardized pain assessment tools.
- This is different from standardized outcomes assessment questionnaires.
- This measure identifies the percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.
- This measure is to be reported for each visit occurring during the reporting period for patients seen dur-
ing the reporting period.
• There is no diagnosis associated with this measure.
• This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. CPT codes and patient demographics are used to identify patients who are included in the measure’s denominator.
  – G-codes are used to report the numerator of the measure.
  – When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code.

**Pain Assessment** A clinical assessment of pain through discussions with the patient and use of a standardized tool(s) for the presence and characteristics of pain which may include location, intensity, quality, and onset/duration

**Standardized Tool** – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for pain assessment, include, but are not limited to:
  – Brief Pain Inventory (BPI)
  – Faces Pain Scale (FPS)
  – McGill Pain Questionnaire (MPQ)
  – Multidimensional Pain Inventory (MPI)
  – Neuropathic Pain Scale (NPS)
  – Numeric Rating Scale (NRS) Oswestry Disability Index (ODI)
  – Roland Morris Disability Questionnaire (RMDQ)
  – Verbal Descriptor Scale (VDS)
  – Verbal Numeric Rating Scale (VNRS)
  – Visual Analog Scale (VAS)

**Follow-Up Plan** – Proposed outline of treatment to be conducted as a result of pain assessment. Follow-up **must** include a planned reassessment of pain and may include documentation of future appointments, education, referrals, pharmacological intervention, or notification of other care providers as applicable.

**Not Eligible** – A patient is not eligible for pain assessment and/or follow-up if the following reason exists:
  – Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others.
  – Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status.
Measure #182 Functional Outcome Assessment (re-assessment = every 30 days)
(Pick one G code each exam/questionnaire visit below AND use G8942 for EVERY daily visit thereafter)

OPTION 1:
*FUNCTIONAL OUTCOME ASSESSMENT AND CARE PLAN DOCUMENTED:
(Exam/Questionnaire visit report G8539 or G8542)
(Daily visit report G8942)

G8539: Documentation of a current functional outcome assessment using a standardized tool AND documentation of a care plan based on identified deficiencies on the date of the functional outcome assessment.

OR

G8542: Documentation of a current functional outcome assessment using a standardized tool; no functional deficiencies identified, care plan not required.

OR

G8942: Documented functional outcomes assessment and care plan within the previous 30 days.

OPTION 2:
*FUNCTIONAL OUTCOME ASSESSMENT NOT DOCUMENTED, PATIENT NOT ELIGIBLE.
(Exam/Questionnaire visit report G8540)
(Daily visit report G8942)

G8540: Documentation that the patient is not eligible for a functional outcome assessment using a standardized tool.

OPTION 3:
*FUNCTIONAL OUTCOME ASSESSMENT NOT DOCUMENTED, REASON NOT GIVEN.
(Exam/Questionnaire visit report G8541 or G8543)
(Daily visit report G8942)

G8541: Functional outcome assessment using a standardized tool not documented, reason not given.

OR

G8543: Documentation of a current functional outcome assessment using a standardized tool; care plan not documented, reason not given.

Measure #182
- This measure documents the use of standardized outcome assessment questionnaires.
- Percentage of patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool AND documentation of a care plan based on identified functional outcome deficiencies.
- This measure is to be reported each visit indicating the appropriate numerator code; however, the assessment is
required to be current as defined for patients seen during the reporting period.

- Documentation of a current functional outcomes assessment must include identification of the standardized tool used.
- Indicate the questionnaire utilized in the patient’s chart.

**Pain Assessment:** The use of a standardized tool assessing pain alone, such as the visual analog scale (VAS), does not meet the criteria of a functional outcome assessment standardized tool.

The intent of the measure is for the functional outcome assessment tool to be utilized at a minimum of every 30 days but reporting is required each visit due to coding limitations. Therefore, for visits occurring within 30 days of a previously documented functional outcome assessment, the numerator quality-data code G8942 should be used for reporting purposes.

- CPT codes and patient demographics are used to identify patients that are included in the measure’s denominator.
- G-codes are used to report the numerator of the measure.
- When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code.

**Standardized Tool** – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for functional outcome assessment include, but are not limited to:

- Oswestry Disability Index (ODI)
- Roland Morris Disability/Activity Questionnaire (RM)
- Neck Disability Index (NDI)
- Physical Mobility Scale (PMS)

**Functional Outcome Assessment** – Questionnaires designed to measure a patient's limitations in performing the usual human tasks of living. Functional questionnaires seek to quantify symptoms, function and behavior directly, rather than to infer them from less relevant physiological tests.

**Current** – A patient having a documented functional assessment within the previous 30 days.

**Functional Outcome Deficiencies** – Impairment or loss of physical function related to neuromusculoskeletal capacity, may include but are not limited to:

- Restricted flexion, extension and rotation, back pain, neck pain, pain in the joints of the arms or legs, and headaches.

**Care Plan** – A care plan is an ordered assembly of expected or planned activities, including observations goals, services, appointments and procedures, usually organized in phases or sessions, which have the objective of organizing and managing health care activity for the patient, often focused upon one or more of the patient’s health care problems. Care plans may include order sets as actionable elements, usually supporting a single session or phase and may also be known as a treatment plan.

**Not Eligible** – A patient is not eligible if the following reasons(s) exist:

- Patient refuses to participate.
- Patient unable to complete questionnaire.
Reporting both measures (#131 AND #182) with THE SAME FORM/S

Both measure #131 and #182 specifically list the Oswestry Disability Index (which is another name for the Oswestry Low Back Disability Index) and the Roland Morris Questionnaire as acceptable standardized tools. You should be able to use the following to satisfy the requirements for both measure #131 and #182:

- Revised Oswestry Low Back Pain Disability Questionnaire.
- Neck Disability Index.
- Roland-Morris Questionnaire.
- These measures are to be reported when filing the claim.

How does outsourcing your insurance billing to Money Tree Billing, LLC compare to processing your billing in-house?

Complete our online Billing Cost Analysis to receive a side-by-side comparison of costs and savings. Visit www.MoneyTreeBillingLLC.com

Dr. Short offers the following services:

- Free e-mail Medicare alerts and updates; simply e-mail Dr. Short and request to be added to his list.
- “Medicare for Chiropractors”: A comprehensive book on Medicare procedures for chiropractors designed to be a training and reference resource.
- Compliance Audits and Office Compliance Program development. A complete on-site audit of you office, procedures, policies and records and development of a customized Office Compliance Program Manual. This is the best protection that you can have against Medicare audits and reviews.

To request any of these options or for more information call Dr. Short at 217-285-2300 or e-mail him at:

chiromedicare@gmail.com

Money Tree Billing, LLC

Your Chiropractic Billing Team

Our goal is your success...

- A stress-free alternative to in-house billing
- Saves you time & overhead costs
- Allows you to remain patient-focused
- Our “No Claim Left Behind Guarantee” means you have nothing to lose!

"What sets them apart from all other billing services is that they have STRONG chiropractic philosophy and they have been billing chiropractic claims, not medical claims for years. They walk their talk and they will be in your corner all of the way.”

~Dr. Keith Billstein, Chiropractor

Schedule a no-obligation consultation today!

763-331-0358

Follow us on Facebook for the latest in chiropractic billing and success tips!