

Medical Massage Billing, Coding & Documentation

Target Coding

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- Certified Professional Compliance Officer (CPCO)
- Author of 10 Chiropractic Compliance & Documentation Training Manuals
- Contributing Writer to Chiropractic Economics & Dynamic Chiropractic
- Featured Speaker for The Coding Institute, Parker Seminars & Foot Levelers
- Guest Speaker at Many National & State Chiropractic Conventions



Massage Therapy Billing, Coding & Documentation

Key Points

- Medical massage vs. wellness massage.
- Medical massage = medically necessary.
- Wellness massage = typically not insurance payable.
- Medically necessary billing, need NPI #, go thru credentialing and contracting.



Massage Therapy Billing, Coding & Documentation

Key Points

- Scope of practice.
- Must check with your state licensing board prior to implementing any of the information in this presentation.
- Get liability/malpractice insurance.
- Call to verify coverage prior to billing.
- Some carriers do not reimburse when LMT provides service.



Massage Therapy Billing, Coding & Documentation

CMS definition of Medical Necessity:

A service, treatment, procedure, equipment, drug or supply provided by a hospital, physician, or other health care provider that is required to identify or treat a beneficiary's illness or injury and which is, as determined by the contractor: **a)** consistent with the symptom(s) or diagnosis and treatment of the beneficiary's illness or injury; **b)** appropriate under the standards of acceptable medical practice to treat that illness or injury; **c)** not solely for the convenience of the participant, physician, hospital, or other health care provider; and **d)** the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the beneficiary and accomplishes the desired end result in the most economical manner.

The items or services being provided must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Patient Flow



Massage Therapy Billing, Coding & Documentation

1. Patient calls to make appointment.
2. Go through typical questions (e.g., referral, auto accident related, insurance information, seen by anyone else for condition, etc.).
3. Patient arrives at office and fills out health history questionnaire (Auto, WC, Pediatric, etc.).
4. Make sure the questionnaire has financial information.
Example, *"Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility."*



Massage Therapy Billing, Coding & Documentation

Initial Patient Visit Intake Forms:

- Health History Intake Questionnaire (Case Specific)
- Financial Policy
- Assignment of Benefits
- Authorization to Release Information
- Lien/Letter of Protection
- Informed Consent
- Consent to Treat Minor
- Acknowledgement Form for Non-payable Services
- Medicare ABN & Non-covered Services Form
- Outcome Measurement Forms
- Notice of Privacy Practices (HIPAA)
- State Specific Forms

	<p style="text-align: center;">Notice of Privacy Practices</p> <p>Practice Name, Address, Tel. & Email</p> <p>This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.</p> <p><u>Your Rights</u></p> <p>When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.</p> <p><u>Get an electronic or paper copy of your medical record:</u></p> <p>You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.</p> <p><u>Ask us to correct your medical record:</u></p> <p>You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.</p> <p><u>Request confidential communications:</u></p> <p>You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.</p> <p><u>Ask us to limit what we use or share:</u></p> <p>You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.</p> <p><u>Get a list of those with whom we've shared information:</u></p> <p>You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.</p> <p><u>Get a copy of this privacy notice:</u></p> <p>You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.</p>	
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Notice of Privacy Practices

Practice Name, Address, Tel. & Email

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications:

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.

Ask us to limit what we use or share:

You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information:

You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

Choose someone to act for you:

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hippa/complaints. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

Marketing purposes. Sale of your information. Sharing of psychotherapy notes.

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you:

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization:

We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services:

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research:

We can use or share your information for health research.

Comply with the law:

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:

We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions:

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

[Our Responsibilities](#)

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice:

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

Contact Person:

All questions concerning this notice, or requests made pursuant to it, should be addressed to:
name and email of compliance officer, practice address and telephone.

Patient Acknowledgment:

I acknowledge that I have reviewed this office's Notice of Privacy Practices, acknowledge that I may refuse to sign this acknowledgment if I wish, and agree to the liability limitations explained therein. I have the right to obtain a paper copy of this notice.

Patient Printed Name

Patient Signature or legal representative

If legal representative, state relationship

Date

Massage Therapy Billing, Coding & Documentation

6. Make sure patient fills out the questionnaire completely.
7. Patient sees the MD/DC first. Patient can see MT first if allowed in your state.
8. MD/DC performs history, examination and medical decision making.
9. MD/DC establishes the diagnosis.
10. If MD/DC is going to treat, then establish patient clinical goals, list services to be rendered and create a treatment schedule - this constitutes a written treatment plan/POC.
11. If referring patient, MD/DC should fill out a Referral/Order Form.



	<p>ABC Chiropractic Center - Dr. Chiropractor 1234 Main Street - City, ST 12345 Tel: (123) 456-7890</p> <p>Massage Therapy Referral/Order Form</p>																	
	<p>Patient Name: <i>Mary Smith</i> Age: <i>38</i> Date: <i>10/15/2011</i></p> <p>Patient Address: <i>1234 Cedar Street, City, ST 12345</i></p> <p>Referring Provider Name: <i>Dr. Chiropractor</i></p> <p>Referring Provider Address & Tel #: <i>see above</i></p> <p>Purpose of Referral: <i>evaluate and treat</i></p> <p>Patient Diagnosis(es): <i>muscle spasms, neck pain, cervical disc degeneration, stiffness in left thigh, low back pain, osteoarthritis of right shoulder joint, lumbar disc degeneration, stiffness in left arm, thoracic pain, pain in right hand, cervical sprain and strain, pain in left lower leg.</i></p> <p>Recommended Therapy Services: <i>manual therapy to the cervical, upper thoracic and bilateral upper extremities for 15 minutes per visit, massage therapy to the lower thoracic and lumbar regions for 15-30 minutes per visit.</i></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Hot/Cold packs (97010)</td> <td>Site _____</td> </tr> <tr> <td><input type="checkbox"/> Mechanical traction (97012)</td> <td>Site _____</td> </tr> <tr> <td><input type="checkbox"/> TENS (unattended) (97014/97033)</td> <td>Site _____</td> </tr> <tr> <td><input type="checkbox"/> Ultrasound (97035)</td> <td>Site _____</td> </tr> <tr> <td><input type="checkbox"/> Therapeutic exercises (97110)</td> <td>Site _____</td> </tr> <tr> <td><input type="checkbox"/> Massage therapy (97124)</td> <td>Site _____</td> </tr> <tr> <td><input type="checkbox"/> Manual therapy (97140)</td> <td>Site _____</td> </tr> <tr> <td><input type="checkbox"/> Other (____)</td> <td>Site _____</td> </tr> </table> <p>Recommended Treatment Schedule: <i>3 times per week for one month then re-evaluate</i></p> <p>Referring Provider Signature: <i>Dr. Chiropractor</i></p>	<input type="checkbox"/> Hot/Cold packs (97010)	Site _____	<input type="checkbox"/> Mechanical traction (97012)	Site _____	<input type="checkbox"/> TENS (unattended) (97014/97033)	Site _____	<input type="checkbox"/> Ultrasound (97035)	Site _____	<input type="checkbox"/> Therapeutic exercises (97110)	Site _____	<input type="checkbox"/> Massage therapy (97124)	Site _____	<input type="checkbox"/> Manual therapy (97140)	Site _____	<input type="checkbox"/> Other (____)	Site _____	
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	<p><small>NOTICE: If you have received this Target Coding MT REFERRAL/ORDER FORM and it did not come directly from Target Coding, then you are an unauthorized user of this copyrighted information. Copyright © 2016 Target Coding. All Rights Reserved.</small></p>																	

ABC Chiropractic Center - Dr. Chiropractor
1234 Main Street - City, ST 12345
Tel: (123) 456-7890

Massage Therapy Referral/Order Form

Patient Name: *Mary Smith*

Age: *38*

Date: *10/15/20XX*

Patient Address: *1234 Center Street, City, ST 12345*

Referring Provider Name: *Dr. Chiropractor*

Referring Provider Address & Tel. #: *see above*

Purpose of Referral: *evaluate and treat*

Patient Diagnosis(es): *muscle spasm, neck pain, cervical disc degeneration, stiffness in left thigh , low back pain, contracture of right shoulder joint, lumbar disc degeneration, stiffness in left arm, thoracic pain, pain in right hand, cervical sprain and strain, pain in left lower leg.*

Recommended Therapy Services: *manual therapy to the cervical, upper thoracic and bilateral upper extremities for 15 minutes per visit. massage therapy to the lower thoracic and lumbar regions for 15-30 minutes per visit.*

_____ Hot/Cold packs (97010)	Site _____
_____ Mechanical traction (97012)	Site _____
_____ EMS unattended (97014/G0283)	Site _____
_____ Ultrasound (97035)	Site _____
_____ Therapeutic exercises (97110)	Site _____
_____ Massage therapy (97124)	Site _____
_____ Manual therapy (97140)	Site _____
_____ Other (_____)	Site _____

Recommended Treatment Schedule: *3 times per week for one month then re-evaluate*

Referring Provider Signature: *Dr. Chiropractor*

Sample Patient:

- Mr. Williams was involved in automobile accident.
- He was at a total stop when his vehicle was suddenly rear-ended.
- He felt immediate neck pain, left shoulder pain & pain in both wrists.



History/Consultation



Massage Therapy Billing, Coding & Documentation

History Key Points

- Chief complaint
- HPI
- ROS
- PFSH



Review of Systems

Patient Name: _____ Patient File #: _____ Today's Date: ____/____/____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional: None Chills Dyspnea/Dysrhythmia Fatigue Fever Night Sweats Weight Gain Weight Loss	Cardiovascular: None Angina (chest pain or discomfort) Chest Pain Circulation (leg pain or achiness) Heart Murmur Heart Problems Orthopnea (difficulty breathing while lying) Pulsations (irregular or forceful) Heart Beat Paroxysmal Nocturnal Dyspnea (shortness of breath at night) Shortness of Breath Swelling of Legs Ulcers Varicose Veins	Endocrine: None Cold Intolerance Diabetes Excessive Appetite Excessive Hunger Excessive Thirst Frequent Urination Goiter Hair Loss Heat Intolerance Unusual Hair Growth Voice Changes	Allergy: None Anaphylaxis (history of) Food Intolerance Itching Nasal Congestion Sneezing
Eyes/Vision: None Blindness Blurred Vision Cataracts Change in Vision Double Vision Eye Pain Field Cuts Glaucoma Itching (around the eyes) Photophobia Tearing Wears Glasses or Contacts	Gastrointestinal: None Abdominal Pain Belching Black, Tarry Stools Constipation Diarrhea Difficulty Swallowing Heartburn Hemorrhoids Indigestion Jaundice (yellowing of the skin) Nausea Rectal Bleeding Abnormal Stool Color (quality) Abnormal Stool Consistency Vomiting Vomiting Blood	Skin: None Changes in Nail Texture Hair Growth Hair Loss Changes in Skin Color Itching Pruritus (itchiness, prickling, or tingling) Rash History of Skin Disorders Skin Lesions or Ulcers Verrucae	Hematology: None Anemia Bleeding Blood Clotting Blood Transfusion(s) Bruises easily Fatigue Lymph Node Swelling
Ears, Nose and Throat: None Bleeding Dental Implants Dentures Difficulty Swallowing Discharge Dizziness Ear Drainage Ear Infection(s) Ear Pain Fainting Headaches Head Injury (history of) Hearing Loss Hoarseness Loss of Smell Nasal Congestion Nose Bleeds Pain Nasal Mucosa Rhinorrhea (runny nose) Sinus Infections Sneezing Sore Throat Tinnitus (ringing in the ears) TMJ Disorder	Respiratory: None Asthma Coughing up blood Shortness of Breath Sputum Production Wheezing	Nervous System: None Dizziness Facial Weakness Headaches Limb Weakness Loss of Consciousness Loss of Memory Numbness Seizures Sleep Disturbance Slurred Speech Stress Strokes Tremors Unsteadiness of Gait	Psychological: None Apathy (inability to experience joy or enjoy life) Anxiety Appetite Changes Behavioral Change(s) Bipolar Disorder Confusion Convulsions Depression Insomnia Memory Loss Mood Change(s)
Female: None Birth Control Therapy Breast Lumps/Pain Burning Urination Cramps Frequent Urination Hormone Therapy Irregular Menstruation Urine Retention Vaginal Bleeding Vaginal Discharge			Male: None Burning Urination Erectile Dysfunction Frequent Urination Hematuria or Hemoglobin Prostate Problems Urine Retention

Patient Signature: _____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient:

Doctor Signature: _____ Date: _____

Call 1.800.270.7044, email info@targetcoding.com or visit targetcoding.com for more information.

Review of Systems

Patient Name: _____

Patient File #: _____

Today's Date: ____/____/____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:

- ☐ **None**
- ☐ Chills
- ☐ Daytime Drowsiness
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

Eyes/Vision:

- ☐ **None**
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Itching (*around the eyes*)
- ☐ Photophobia
- ☐ Tearing
- ☐ Wears Glasses or Contacts

Ears, Nose and Throat:

- ☐ **None**
- ☐ Bleeding
- ☐ Dental Implants
- ☐ Dentures
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dizziness
- ☐ Ear Drainage
- ☐ Ear Infection(s)
- ☐ Ear Pain
- ☐ Fainting
- ☐ Headaches
- ☐ Head Injury (*history of*)
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Rhinorrhea (*runny nose*)
- ☐ Sinus Infections
- ☐ Snoring
- ☐ Sore Throats
- ☐ Tinnitus (*ringing in the ears*)
- ☐ TMJ Disorder

Cardiovascular:

- ☐ **None**
- ☐ Angina (*chest pain or discomfort*)
- ☐ Chest Pain
- ☐ Claudication (*leg pain or achiness*)
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Orthopnea (*difficulty breathing while lying*)
- ☐ Palpitations (*irregular or forceful heart beat*)
- ☐ Paroxysmal Nocturnal Dyspnea (*shortness of breath at night*)
- ☐ Shortness of Breath
- ☐ Swelling of Leg(s)
- ☐ Ulcers
- ☐ Varicose Veins

Gastrointestinal:

- ☐ **None**
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice (*yellowing of the skin*)
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber (*quality*)
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

Respiration:

- ☐ **None**
- ☐ Asthma
- ☐ Coughing up blood
- ☐ Shortness of Breath
- ☐ Sputum Production
- ☐ Wheezing

Endocrine:

- ☐ **None**
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

Skin:

- ☐ **None**
- ☐ Changes in Nail Texture
- ☐ Changes in Skin Color
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia (*numbness, prickling, or tingling*)
- ☐ Rash
- ☐ History of Skin Disorders
- ☐ Skin Lesions or Ulcers
- ☐ Varicosities

Nervous System:

- ☐ **None**
- ☐ Dizziness
- ☐ Facial Weakness
- ☐ Headaches
- ☐ Limb Weakness
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors
- ☐ Unsteadiness of Gait

Allergy:

- ☐ **None**
- ☐ Anaphylaxis (*history of*)
- ☐ Food Intolerance
- ☐ Itching
- ☐ Nasal Congestion
- ☐ Sneezing

Hematology:

- ☐ **None**
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusion(s)
- ☐ Bruises easily
- ☐ Fatigue
- ☐ Lymph Node Swelling

Psychological:

- ☐ **None**
- ☐ Anhedonia (*inability to experience joy or enjoy life*)
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Change(s)
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Mood Change(s)

Female:

- ☐ **None**
- ☐ Birth Control Therapy
- ☐ Breast Lumps / Pain
- ☐ Burning Urination
- ☐ Cramps
- ☐ Frequent Urination
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

Male:

- ☐ **None**
- ☐ Burning Urination
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy or Dribbling
- ☐ Prostate Problems
- ☐ Urine Retention

Patient Signature: _____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient:

Doctor Signature

Date

Examination



Massage Therapy Billing, Coding & Documentation

- **Palpation**: palpate for tenderness, pain, crepitation, masses, swelling, edema, contusions, etc.
- **Subluxation**: evaluate for subluxations, segmental dysfunction, asymmetry, fixation, restriction, misalignment, joint stability, joint laxity, etc.
- **Range of Motion**: measure for restrictions and/or pain.
- **Muscle/ligament**: measure strength, tone, hypertonicity, spasm, muscle weakness, atrophy, abnormal muscle movements, tissue/tone abnormalities.



Massage Therapy Billing, Coding & Documentation

- General appearance, posture
- Vital signs - measure 3 of the following 7: sitting or standing blood pressure, supine blood pressure, pulse rate/regularity, respiration, temperature, height, weight
- Gait/Station
- Reflexes
- Sensation
- Skin
- Brief Mental Assessment



The Diagnosis



Massage Therapy Billing, Coding & Documentation

The Diagnosis

- Create a bread-crumb trail.
- Symptoms + Exam Findings + Diagnostic Results = **Diagnosis**
- The clinical rationale for choosing a diagnosis must be evident in the notes.
- Short-term, moderate-term and long-term treatment groups.



Massage Therapy Billing, Coding & Documentation

Laterality

- Laterality did not exist in ICD-9.
- In ICD-10, the right side is designated by the number 1 and the left side is designated by the number 2.
- If the side is not identified in the medical record, assign the code for the unspecified side.
- Example: M54.31 (right side sciatica), M54.32 (left side sciatica)



Massage Therapy Billing, Coding & Documentation

Other & Unspecified Codes

Other: use when the patient record **provides detail** for which a specific code **does not** exist.

- M62.838 (**other**, muscle spasm) (cervical)

Unspecified: use when the information in the patient record is **insufficient** to assign a more specific code.

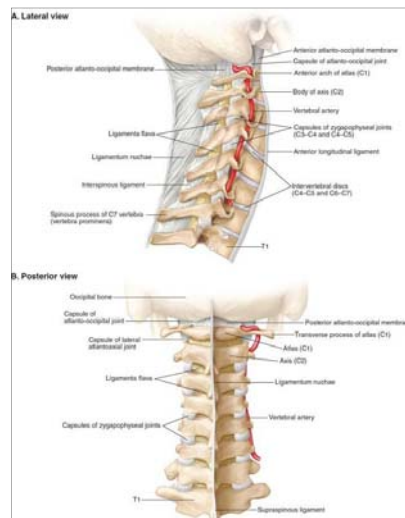
- M25.519 (**unspecified**, shoulder pain)



Massage Therapy Billing, Coding & Documentation

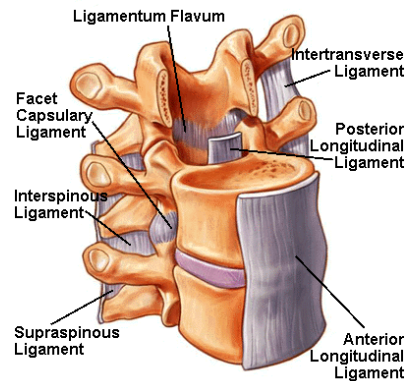
Cervical Sprain

- **S13.4XXA:** Sprain of cervical ligaments, initial encounter
- **S13.4XXD:** Sprain of cervical ligaments, subsequent encounter
- **S13.4XXS:** Sprain of cervical ligaments, sequelae



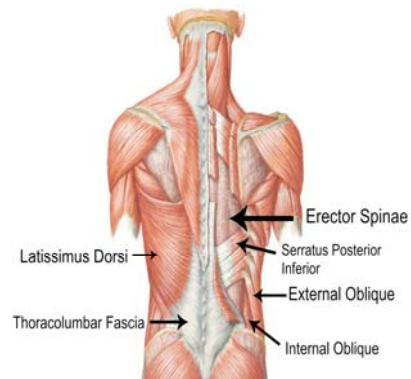
Lumbar Sprain

- **S33.5XXA:** Sprain of lumbar ligaments, initial encounter
- **S33.5XXD:** Sprain of lumbar ligaments, subsequent encounter
- **S33.5XXS:** Sprain of lumbar ligaments, sequelae



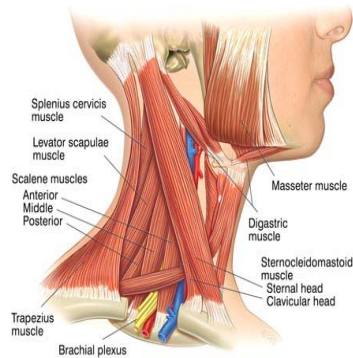
Lumbar Strain

- **S39.012A:** Strain of low back muscles, initial encounter
- **S39.012D:** Strain of low back muscles, subsequent encounter
- **S39.012S:** Strain of low back muscles, sequelae



Cervical Strain

- **S16.1XXA:** Strain of muscle, fascia and tendon at neck level, initial encounter
- **S16.1XXD:** Strain of muscle, fascia and tendon at neck level, subsequent encounter
- **S16.1XXS:** Strain of muscle, fascia and tendon at neck level, sequelae



Disc Disorder: herniation, bulge, protrusion, prolapse, rupture, extrusion with radiculopathy (nerve root compression)

- Cervical examples: M50.11, M50.12, M50.13
- Lumbar examples: M51.15, M51.16, M51.17

Disc Displacement: herniation, bulge, protrusion, prolapse, rupture, extrusion without nerve root compression

- Cervical examples: M50.21, M50.22, M50.23
- Lumbar examples: M51.25, M51.26, M51.27

Disc Degeneration:

- Cervical examples: M50.31, M50.32, M50.33
- Lumbar examples: M51.35, M51.36, M51.37



<u>Description</u>	<u>ICD-10</u>
Acute post-traumatic headache	G44.311 (intractable) G44.319 (not intractable)
Chronic post-traumatic headache	G44.321 (intractable) G44.329 (not intractable)
Dizziness	R42
Sleep disturbance	G47.9
Ligament laxity	M24.28
Tingling/pins/needles	R20.2
Abnormal jaw closure	M26.51
Limited mandibular ROM	M26.52
TMJ pain/dysfunction	M26.60

<u>Description</u>	<u>ICD-10</u>
Tinnitus	H93.11 (right ear) H93.12 (left ear) H93.13 (bilateral)
Nausea	R11.0
Knee contusion	S80.01X_
Diffuse TBI w/o loss of consciousness	S06.2X0_
Diffuse TBI w/ brief loss of consciousness	S06.2X1_ (30 min or less)
Concussion w/o loss of consciousness	S06.0X0_

Clinical Goals



OATs (Outcome Assessment Tools):

- GROC (Global Rating of Change Scale)
- SF-36, SF-12, SF-8
- STarT Back Screening Tool (Keele)
- Neck Disability Index
- Oswestry Low Back Pain Disability Index
- Roland-Morris Disability Questionnaire
- DASH - Disability of Arm, Shoulder & Hand
- The Lower Extremity Functional Scale - this is a questionnaire containing 20 questions about a person's ability to perform everyday tasks
- Berg Balance Scale - for functional balance tests this is considered the gold standard
- The Tinetti Test or Performance Oriented Mobility Assessment is a common clinical test for assessing a person's static and dynamic balance abilities named after one of the inventors, Mary Tinetti

Neck Index

Form NCI-100

Patient Name _____ Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☒ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Personal Care

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☒ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but I manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☒ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☒ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Reading

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☒ I cannot read as much as I want because of moderate neck pain.
- ☐ I can hardly read at all because of severe neck pain.
- ☐ I cannot read at all because of neck pain.

Driving

- ☐ I can drive my car without any neck pain.
- ☒ I can drive my car as long as I want with slight neck pain.
- ☐ I can drive my car as long as I want with moderate neck pain.
- ☐ I cannot drive my car as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I cannot drive my car at all because of neck pain.

Concentration

- ☒ I can concentrate fully when I want with no difficulty.
- ☐ I can concentrate fully when I want with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating when I want.
- ☐ I have a lot of difficulty concentrating when I want.
- ☐ I have a great deal of difficulty concentrating when I want.
- ☐ I cannot concentrate at all.

Recreation

- ☐ I am able to engage in all my recreation activities without neck pain.
- ☐ I am able to engage in all my usual recreation activities with some neck pain.
- ☒ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ☐ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ☐ I can hardly do any recreation activities because of neck pain.
- ☐ I cannot do any recreation activities at all.

Work

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work but no more.
- ☒ I can only do most of my usual work but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Headaches

- ☒ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Neck Index Score

Index Score = [(Sum of all statements selected / (# of sections with a statement selected x 5)) x 100]

19 ÷ 50 (10x5) = 0.38
x 100 = 38

CPT Codes



Massage Therapy Billing, Coding & Documentation

Supervised Modalities:

- 97010 (hot/cold)
- 97012 (mech. traction)
- 97014/G0283 (unatt. EMS)
- 97016 (vasopneumatic)
- 97018 (paraffin bath)
- 97022 (whirlpool)
- 97024 (diathermy)
- 97026 (infrared)
- 97028 (ultraviolet)



Massage Therapy Billing, Coding & Documentation

Constant Attendance Modalities:

- 97032 (att. EMS)
- 97033 (iontophoresis)
- 97034 (contrast baths)
- 97035 (u/s)
- 97039 (unlisted mod.)
- S8948 (LLLT)



Massage Therapy Billing, Coding & Documentation

Therapeutic Procedures:

- 97110 (ther. ex.)
- 97112 (nmr)
- 97113 (aquatic therapy with ther. ex.)
- 97116 (gt)
- 97124 (massage therapy)
- 97139 (unlisted ther. proc.)
- 97140 (man. therapy)
- 97150 (group ther.)
- 97530 (ther. act.)
- 97535 (ADL)



Massage Therapy Billing, Coding & Documentation

Therapeutic Procedures:

A manner of effecting change through the application of clinical skills and/or services that attempt to improve function. Physician or therapist required to have direct (one-on-one) patient contact.



Massage Therapy Billing, Coding & Documentation

97124: Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion), one or more regions, each 15 minutes

97140: Manual therapy techniques (e.g., mobilization / manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes



Unit Billing for Time-Based Codes



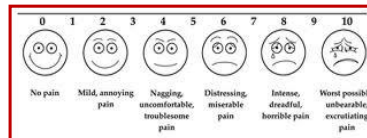
SOAP Notes



Subjective

Pain Scales:

- 1 = very mild, 10 = severe
- VNRS vs. VAS



Symptom Frequency:

- Occasional = 1-25% of the day
- Intermittent = 26-50% of the day
- Frequent = 51-75% of the day
- Constant = 76-100% of the day

Massage Therapy Billing, Coding & Documentation

Objective

- Typically, the objective findings on routine visits include palpation findings, levels articular dysfunction or subluxation, asymmetry, muscle tightness, muscle spasm, poor posture, forward head translation, trigger points, muscle tenderness, inflammation, restricted range of motion, etc.
- More key descriptive terms include off-centered, misalignment, malpositioning, abnormal or decreased spacing, abnormal rotation, limited or restricted motion, hypermobility, hypomobility.

Massage Therapy Billing, Coding & Documentation

Assessment

- Did the patient meet a goal? Are they making progress towards the goals? Did any measurement get better?
- The assessment provides the chance to update the link between the patient-identified functional limitations and the measured impairments.
- Are the present diagnoses and services being rendered still appropriate? Comment on any changes in treatment goals.

Massage Therapy Billing, Coding & Documentation

Plan

- List all services that were provided.
- Patient should continue treatment plan at 3 visits per week for another 2 weeks.
- Patient findings reveal the need for a ortho/neuro referral, additional testing.

Massage Therapy Billing, Coding & Documentation

Home Care Instructions:

- Be specific when giving patients instructions for home care.
- If patients should use ice, tell them how much to use, how long to use it and how to apply it.
- If you provide exercise instructions, be sure to include details such as the specific number of repetitions and sets to be performed.
- Provide exercise sheets and handouts. Have the patient sign and date the forms you give them. Give copy to patient.

Target Coding Sample SOAP Note for Massage Therapy (97124)

Office Name, Address and Telephone #

Patient: Mary Patient

Visit #: (may be required)

Date of Service: 10-15-20XX

Subjective:

The patient is complaining of low back pain and low back stiffness which is present 50% of the day. The patient describes the condition as stiff and annoying. The pain scale is 6/10. The patient stated that her low back feels better since the last visit.

Objective:

Palpatory tenderness revealed in lumbar bilateral paraspinal regions. Lumbar region muscle hypertonicity found in the erector spinae muscles and quadratus lumborum bilaterally. ROM is decreased in lumbar flexion with moderate pain.

Assessment:

Lumbar tenderness and spasm has subsided approximately 20% and the patient was able to bend a little easier since the last visit. At the present time, the patients' response to treatment has been favorable.

Plan & Treatment:

Treatment today included massage therapy to the lumbar erector spinae and quadratus lumborum muscles bilaterally for 30 minutes. Patient is improving as expected. Patient to continue present treatment plan at ___ per ___. The patient is scheduled for her next re-evaluation on ___. The patient tolerated the treatment well and the treatment was without incident.

Massage Therapist Signature

10-15-20XX

Massage Therapist

Date

Target Coding Sample SOAP Note for Massage Therapy (97124)

Office Name, Address and Telephone #

Patient: Mary Patient
Date of Service: 10-15-20XX

Visit #: (may be required)

Subjective:

The patient is complaining of low back pain and low back stiffness which is present 50% of the day. The patient describes the condition as stiff and annoying. The pain scale is 6/10. The patient stated that her low back feels better since the last visit.

Objective:

Palpatory tenderness revealed in lumbar bilateral paraspinal regions. Lumbar region muscle hypertonicity found in the erector spinae muscles and quadratus lumborum bilaterally. ROM is decreased in lumbar flexion with moderate pain.

Assessment:

Lumbar tenderness and spasm has subsided approximately 20% and the patient was able to bend a little easier since the last visit. At the present time, the patients' response to treatment has been favorable.

Plan & Treatment:

Treatment today included massage therapy to the lumbar erector spinae and quadratus lumborum muscles bilaterally for 30 minutes. Patient is improving as expected. Patient to continue present treatment plan at ___ per ___. The patient is scheduled for her next re-evaluation on ___. The patient tolerated the treatment well and the treatment was without incident.

Massage Therapist Signature

10-15-20XX

Massage Therapist

Date

NOTICE: If you have received this Target Coding Sample SOAP Note and it did not come directly from Target Coding, then you are an unauthorized user of this information. Call 1-800-276-7844 or visit www.TargetCoding.com for more information.

1500 Form

The image shows a standard HCPCS Level II 1500 form, which is a claim form for medical services. The form is divided into several sections: Patient Information, Insurance Information, Service Information, and Billing Information. It includes fields for patient name, address, date of birth, sex, race, and ethnicity. It also includes fields for insurance company name, policy number, and group number. The Service Information section includes fields for procedure codes, dates of service, and units. The Billing Information section includes fields for provider name, address, and tax identification number. The form is designed to be filled out by a healthcare provider or billing specialist to submit a claim to an insurance company.

Box 10

10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. AUTO ACCIDENT?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO PLACE (State) _____
c. OTHER ACCIDENT?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO

PI Recordkeeping, Coding & Documentation

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				ICD Ind.
A. _____	B. _____	C. _____	D. _____	
E. _____	F. _____	G. _____	H. _____	
I. _____	J. _____	K. _____	L. _____	


- Enter the codes to identify the patient's diagnosis and/or condition.
- List no more than 12 ICD-10 diagnosis codes.
- Relate lines A - L to the lines of service in 24E by the letter of the line.
- Report ICD-10 codes to the highest level of specificity.
- Do not provide the narrative description of the codes in this field.
- Use "0" in ICD Ind. field.

- Mr. Williams was involved in automobile accident.
- He was at a total stop when his vehicle was suddenly rear-ended.
- He felt immediate neck pain, left shoulder pain & pain in both wrists.
- Exam reveals cervical restricted ROM, jackson compression, valsalva, foraminal compression, spurling, shoulder depression, shoulder abduction, strained cervical muscles, thoracic muscle spasm, left shoulder tenderness, bil. wrist edema, traumatic sub. at C4-C5 & T2-T3.
- MRI reveals a herniated disc at C6-7.

A. M50.12 (combo) **B. S13.4XX_** (c-spr) **C. S16.1XX_** (c-str) **D. S13.150A** (c-sub)
E. S23.120A (t-sub) **F. M25.512** (sh p) **G. M25.431** (wr s) **H. M25.432** (wr s)
I. M62.830 (b-sp) **J. _____** **K. _____** **L. _____**

ICD Ind. [0]

M50.12: cervical rad. – excludes 1 with M54.2 – it's a combo code neck pain with nerve root compression

	<h1 style="margin: 0;">STATEMENT</h1>	
<p>Main Street Massage Center 1234 Main Street, City, ST 12345 T: 1-234-567-8901, E: info@msmc.com W: www.msmc.com Tax ID #: 01-0012345</p>		<p>DATE: JUNE 1, 20XX STATEMENT # 00XX</p>
<p>TO Patient Name Street Address City, ST Zip</p>		
<hr/>		
DIAGNOSES		
M54.2, M62.838		
<hr/>		
DATE	PROCEDURE	TOTAL
6/1/XX	Massage Therapy (97124)	\$75.00
6/3/XX	Manual Therapy (97140)	\$75.00
TOTAL		\$150.00
Paid		\$150.00
COMMENTS: Thank You.		
BALANCE		\$0.00



STATEMENT

Main Street Massage Center

1234 Main Street, City, ST 12345

T: 1-234-567-8901,

E: info@W: www.

Tax ID #: 01-0012345

DATE: JUNE 1, 20XX

STATEMENT # 00XX

TO Patient Name
Street Address
City, ST Zip

DIAGNOSIS			
M54.2, M62.838			

DATE	PROCEDURE		TOTAL
6/1/XX	Massage Therapy (97124)		\$75.00
6/3/XX	Manual Therapy (97140)		\$75.00
		TOTAL	\$150.00
		PAID	\$150.00

COMMENTS: Thank You.

BALANCE \$0.00

Closing Comments:

You must check with all the carriers you bill prior to submitting claims based on the information provided in this presentation to ensure that it is compliant.

Target Coding does not guarantee that the information provided in this presentation will guarantee payment from any insurance carrier or patient.

Target Coding is not responsible for any insurance carrier or managed care organization laws, rules and guidelines that may change following this presentation. Please understand that insurance carrier rules, laws, guidelines and regulations change – so it's important to do your best to stay on top of any changes that may occur by attending seminars, webinars and joining your National and State Professional Associations.




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Guidebook on the Best CPT & ICD Coding Combinations	✓	✓	✓	✓	✓	✓
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Unlimited Seminar Access (live & recorded)	✓	✓	✓	✓	✓	✓
4 Comprehensive Training Manuals	✓	✓	✓	✓	✓	✓
Comprehensive Review of your SOAP notes, Patient Intake Forms, ICD Claims, EOBs, CPT/ICD Codes, Modifiers, Fee Schedules, Cash Plans, Ins. Verification & HIPAA Forms	✓	✓	✓	✓	✓	✓
Monthly Online Training Personalized For Your Office	✓	✓	✓	✓	✓	✓
A Day of Training at Your Office For All DCs, Clinical Staff and Insurance CAAs	✓	✓	✓	✓	✓	✓
MONTHLY FEE	\$99	\$149	\$199	\$299	\$599	\$499/\$699

for more information visit:
TargetCoding.com
 or Call 1.800.270.7044




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The BASIC MEMBERSHIP includes:

- Q & A Support - submit your questions (via e-mail) and get your billing, coding and documentation questions answered within 24-48 hours.
- Access to all Target Coding live webinars. The webinars are given just about every month and we cover many topics. CEUs are not included. You can watch our webinars from most tablets and mobile devices.
- Receive 10-25% off all recorded webinars, training DVDs and seminars (CEUs not included).
- Plus news alerts and updates on chiropractic billing, coding and documentation.
- \$99/month (agreement can be cancelled any time after 1st month).

Member Information: Name: _____

Address, City, State, Zip: _____

Office #: _____ Cell #: _____ Fax #: _____ Email: _____

Credit Card Charges: Member authorizes Target Coding to charge the below credit card \$99 per month beginning with the date below for the services set forth in this agreement. Member can discontinue this agreement at any time after the first month. This agreement is non-transferable.

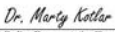
Payment Method: Visa MasterCard AMEX

Credit Card Number: _____ Exp. Date: _____

Cardholder Name: _____ Sec. Code: _____

Credit Card Billing Address & Zip Code if different than above: _____

THE BELOW PARTIES HAVE EXECUTED THIS AGREEMENT FOR THE WRITTEN ABOVE.


 Target Coding Representative Signature

 Date _____

Member Signature

 Date _____


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www.TargetCoding.com • info@targetcoding.com

FREE Coding & Compliance Evaluation

Doctor's Name _____ Today's Date _____
 Address _____ City _____ State _____ Zip Code _____
 Office Tel _____ Fax _____ Email _____ Years in Practice _____
 Are you (circle one): The Clinic Owner Partner Associate Independent Contractor Staff Member Student
 Visits/Week _____ New Patients/Month _____ Services/Month \$ _____ Collections/Month \$ _____
 What % of your practice is: General Insurance _____ PT _____ WC _____ HMO _____ Medicare _____ Cash _____
 How have your collections changed over the last 3 years? (circle one) Increased Decreased No Change
 How do you send your claims? (circle one) In-Office Paper Claims In-Office Electronically Use Outside Billing Co.
 Do you belong to any other Chiropractic Practice Management Group? Yes No If yes, which one: _____
 How did you find out about Target Coding? _____
 Circle Yes or No if you incorporate the following procedures into your practice:

Initial Exams	Yes No	Therapeutic Exercises	Yes No
Consultations	Yes No	Therapeutic Activities	Yes No
ROF's	Yes No	Neuromuscular Reed.	Yes No
Re-Exams	Yes No	Manual Therapy	Yes No
X-rays	Yes No	Massage Therapy	Yes No
Computerized Range-of-Motion	Yes No	Gait Training	Yes No
Computerized Muscle Testing	Yes No	ADL's	Yes No
Nutrition Therapy	Yes No	Acupuncture	Yes No
Surface EMG	Yes No	Extremity Adjusting	Yes No
Outcome Assessments	Yes No	Orthotics	Yes No
EMS	Yes No	Extremity Strapping	Yes No
Ultrasound	Yes No	Health Care Classes	Yes No
Mechanical Traction	Yes No	TENS Units	Yes No

What is the average number of CPT codes that you bill per visit? (circle one) 1 2 3 4

If we could help you improve one thing in your practice, what would it be? _____

After completing this evaluation, please fax it to 1-854-389-3491. Thank You ☺

15 Minutes Could Help
You Collect an Extra
15% or More

**Call or e-mail to schedule
your 15 minute call.**

T: 1-800-270-7044

E: info@targetcoding.com



1.800.270.7044 | TargetCoding.com

Contact Info:

- **E: info@targetcoding.com**
- **W: TargetCoding.com**
- **T: 1-800-270-7044**
- **F: 1-844-831-2347**

Thank
You!