

moving in the right direction

Mechanical Diagnosis And Therapy™
of the spine and extremities

▶▶ Navigating the Challenges of Being a Healthcare Provider: What are the Risks for Physical Therapists?

Helene M. Fearon, PT and Stephen M. Levine, PT, DPT, MSHA

Becoming a physical therapist of advanced clinical or business skill is a goal that many have accomplished through arduous planning, long hours, and personal sacrifice. After all the work involved, it is unlikely most want to risk it all by thinking and plotting how to best defraud the federal government or a third party payer – in fact, the vast majority of physical therapists demonstrate a high amount of professional satisfaction, and go to work each day thinking about the positive impact they can have on their patients and the communities they serve. But this is not accomplished without the struggles that anyone would experience in an environment that encourages an increased scrutiny from healthcare regulators and third party insurance review organizations. Unfortunately, over the past decade, providers, including physical therapists, are working harder and spending longer hours in the clinic overwhelmed with paperwork to meet the increasingly burdensome regulatory requirements. All of this is done while juggling the management of your practice, which is inevitably facing negative impacts on growth due to lower third party reimbursement, higher patient co-pays, and a depressed economy.

On one hand, physical therapists who work in private practice environments often cite the reason for their preference in providing care in this setting is that it allows them to be creatively in charge of providing the highest level of clinical care to their patients and clients with their own unique touch and style. But then, there is always that pause and the inevitable footnote addressing the reality of needing to keep up with the things that must get done during each day, every month, and always at the end of the calendar year to stay out of an auditor's crosshairs. Alternatively, therapists who work in other settings, both outpatient and inpatient, often get lulled into the sense that the organization in which they practice insulates them from the reality of today's volatile healthcare environment, and falsely believe it minimizes or eliminates their risk related to knowing and adhering to practice act requirements and third party regulation. In all settings, physical therapists universally feel they simply do not have time to efficiently and effectively stay current with all the rules and regulations related to being a healthcare provider in 2010.

However, the consequences for not paying close attention and developing strategies to adhere to the rules of a third party payment environment have become too big to ignore, particularly in light of passage of the Patient Protection and Accountable Care Act, known most commonly as "healthcare reform". Healthcare in general, and physical therapy specifically, remains a target for audit and investigation in order to minimize fraud, waste, and abuse in the healthcare system, particularly in the Medicare and Medicaid programs. And the recently passed healthcare reform legislation allows for recovered funds to be used to assist in paying for the identified 37 million plus uninsured Americans who will be covered under this reform process.

Although there may be few who are intentionally committing **Fraud**, which requires *knowingly and willfully doing something to obtain money under false or fraudulent pretenses*, there are far more physical therapists who fall into

the category of abuse when it comes to their coding, billing and practice management procedures. Abuse is defined as *"That which may directly or indirectly result in unnecessary costs to the Medicare or Medicaid program, improper payment, or payment for services which fail to meet professionally recognized standards of care, or that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment."*

"...therapists who work in other settings, both outpatient and inpatient, often get lulled into the sense that the organization in which they practice insulates them from the reality of today's volatile healthcare environment, and falsely believe it minimizes or eliminates their risk..."

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The most common area where physical therapists may unknowingly tread is a violation of the civil statute known as the False Claims Act (31 U.S.C. §3729(a)), (the Act). A

health care provider can be found guilty of submitting a false claim if he/she:

- Knowingly presents, or causes to be presented a false or fraudulent claim for payment or approval;
- Knowingly makes, uses, or causes to be made, a false record or statement to get a false or fraudulent claim paid or approved;
- Conspires to defraud the Government by getting a false claim paid or approved; or
- Knowingly makes, uses, or causes to be made, a false record or statement to conceal, avoid, or decrease an obligation to pay money or property to the Government.

The liability under the False Claims Act is three times the loss to the government plus penalties of \$5,000 to \$10,000 per claim, and the stakes have become higher in recent years as government agencies interpret violation of the law as an individual who either knew or should have known that what they were doing was incorrect. The concepts of "knowing" and "knowingly" are specifically identified in the Act as someone who:

- Has actual knowledge of the information;
- Acts in deliberate ignorance of truth or falsity of information; or
- Acts in reckless disregard of the truth or falsity of the information, and ***no specific intent to defraud is required.***

The top five audit flags in physical therapy documentation can be summarized as follows:

- ❖ Lack of accurate reporting of time in relationship to provision of clinical services
- ❖ Lack of support for reported interventions requiring one to one contact
- ❖ Lack of progress documented over episode of care
- ❖ Treatment that solely or primarily involves passive care (including modalities) over majority of episode of care, and
- ❖ Lack of functional context in the documentation of evaluation, treatment and discharge.

All of these flags can lead third party payers to a determination of a **lack of medical necessity**, which can constitute abuse as described above. Four out of five of these require review of the medical record in order to come to this conclusion, and review of medical records, often after the claim has been processed and paid, is happening with far greater frequency over the past several years, and will likely continue.

So, why would therapists trained in the McKenzie method be at an increased risk for negative consequences of an audit, even in situations where they are successful in treating patients and achieving significantly improved outcomes? The answer often lies in the language that therapists trained in the McKenzie approach to patient care use to communicate (and document) their diagnostic and clinical findings, which does not easily translate to justification of medical necessity as required by most third party payers.

When reviewing the McKenzie classification system and assessment forms through the eyes of an auditor, particularly a Medicare reviewer, it is clear that the classifications of dysfunction, derangement, and postural, while helpful to the McKenzie therapist, do not demonstrate a connection to functional

limitations that are a requirement under the Medicare benefit for therapy services. Abbreviations on assessment forms, such as FIS, EIS, FIL, EIL, and SGIS offer no understandable relationship to measurable functional limitations through which an auditor will evaluate progress through a therapy episode of care.

Therapists trained in the McKenzie Method must develop or enhance the skill of communicating an international classification system and resultant treatment in a way that is meaningful to the entity paying the claim. In order to minimize the risk of negative audit, or worse, this skill is as important to practice management as clinical skills are in achieving identified functional outcomes. If documentation cannot demonstrate medical necessity as required under a third party payment system, then the unsuspecting (although clinically excellent) therapist may find themselves accused of abusive practices, at best having to pay back any money provided through the Medicare or private payment system, and at worst, having to defend against accusations of fraud and abuse!

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▶▶ Driving it Home: Applying the History to the Examination

Kim Greene, PT, Dip. MDT

You have just finished taking the credentialing exam and all that hard work is finally starting to pay off. Over the last three months, you have reduced a lateral shift deformity, remodeled an ANR, and referred a patient back to the physician for confirmation that she has MS. You feel like you have superhuman powers. You have dreams of opening your own clinic with your name in lights: **Load Master Inc, PT**. But there is one remaining obstacle: **EFFICIENCY IN THE EXAMINATION**. You are as efficient as an old Ford Pinto, assessing only eight patients a day. How can you be successful at this rate? What information from the history will help guide your examination? Where do you start on the examination form? These are all questions that are addressed during the Diploma Program. Knowing how to make the examination flow efficiently requires that you take a first-class history and then apply it to the examination, a skill that takes practice. The following suggestions will help fine tune your examination so that you perform like a Lexus instead of a Pinto.

First and often forgotten, the postural assessment allows you to jump-start the examination by assessing the effect of alternate postural positions. As those of you who have seen Robin McKenzie in action know, he frequently spends 10 minutes assessing the effects of posture correction. This often requires adjusting the size of the roll, as well as changing the location of the roll or the position of the patient to get a positive response. You should also note that not everyone will benefit from a lumbar roll. If you suspect a derangement, some patients will need time to reduce before they can tolerate any extension. This is often the case if the patient refuses to sit or presents with a deformity. Some common mistakes in this portion of the examination include:

1. Failing to determine the location of symptoms before and during posture correction
2. Failing to spend enough time in the corrected position to accurately assess effect
3. Spending too much time on posture correction when symptoms are produced only with prolonged sitting
4. Failing to determine if lateral shift is relevant.

Overlooking the neurological examination will result in the loss of valuable baselines, causing the examiner to hydroplane. Significantly, you must perform a neurological examination before the repeated movement testing if the patient describes symptoms into the extremities. Students often neglect this portion of the exam, especially if the patient denies spinal pain or describes only weakness. Even if the most distal symptom does not appear relevant, however, you must complete a neurological exam in order to notify

the physician of a worsening scenario. Our ability to quickly identify these patients is an immense selling point of the MDT method and must always be on the forefront of the assessment process. A few reminders when assessing neurological status:

1. A positive tension sign must reproduce the patient's concordant symptoms
2. Greater than two myotome/dermatome levels warrants concern and should be communicated to the physician
3. The presence of symptoms in four extremities requires a more thorough neurological examination
4. Positive upper motor neuron signs cannot be disregarded and necessitate immediate referral to the physician.

In the movement loss portion of the exam, therapists frequently cruise right through, forgetting to slow down to assess important aspects. Documenting PDM, deviations, ERP and quality of movement in the pain column supports classification. With functional activities such as bending, reaching, and turning, it is always pertinent to ask the patient if this is their "normal motion." Often this is not obvious to the patient until the movement is performed. And if, for example, the patient admits that she has not been able to touch her toes "in years," then these notations should be documented accordingly.

At last, you are in the final stretch and can start the repeated movement portion of the examination. This can feel as if you are on a roundabout with no easy exit as you perform the test movements like a robot, testing each movement in the order it appears on the form. To avoid this detour, it is crucial to refer back to the history. The history must guide the exam in determining starting positions for direction or load. For example, if the provisional classification is an acute derangement and you initiate repeated movements in a loaded position, the patient will deflate like a flat tire. You'll be stuck on the side of the road for several days until the patient recovers, morphing Load Master into Load Disaster.

By contrast, if a patient is describing a chronic, unchanging presentation, you will most likely need to explore multiple repetitions followed by overpressure and mobilization to determine classification. Many students stop testing after 10-20 repetitions and change the loading strategy or direction, assuming they have come to a dead end, when in fact they could learn much more information by performing more repetitions with more force.

And remember that many patients need time to reduce. Starting the exam with static testing often provides the most guidance to direction, but students starting the Diploma program often have never utilized this valuable tool. Simply listening to the patient and applying the information from the history will save you time. Before too long, you'll be able to fly through your evaluations and Load Master Inc. will be the talk of the town. Good luck! ■

►► Patient empowerment through education to reduce a challenging Lateral Shift Deformity

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INTRODUCTION

Mechanical Diagnosis and Therapy (MDT) utilizes the symptomatic and mechanical responses to loading strategies to determine treatment. We often speak of force progressions to achieve reduction, but at times doing so is a disservice to the patient. A client's involvement is not only key to reduction, but is essential for their understanding of how to prevent and deal with future occurrences. Robin McKenzie claims that a client can, with proper guidance, achieve resolution of the condition while avoiding therapist dependence.

If there is the slightest chance that a patient can be educated in any method that enables him to reduce his own pain and disability using his own understanding and resources, he should receive that education. Every patient is entitled to the information, and every therapist should be obliged to provide it (McKenzie 1989).

This case study describes the use of patient education coupled with an MDT assessment to reduce a Lateral Shift Deformity.

Refer to the completed assessment form for this case study posted in the MDT Resource Center at www.mckenziemdt.org/resource.cfm.

CASE

A 76 year old male presented to the clinic with a three week history of intermittent symptoms into the left back/thigh following bowling. He reported being unable to fully stand erect or walk any significant distance. His prescription stated "Spinal Stenosis" and he reported having two total knee replacements that had not been fully rehabilitated. No other significant health findings were indicated. The client demonstrated an antalgic gait and a visually significant Right Lateral Shift Deformity. Attempts at correction of the shift in standing were unsuccessful, but the client noted a decrease in symptoms as well as the ability to ambulate further following sustained Right Rotation in Flexion. The client was educated on the centralisation phenomenon and the importance of adjusting position in response to the most distal symptom. An initial exercise program of sustained Right Rotation in Flexion for 5-10 minutes every hour was instructed.

At follow-up 48 hours later, the client noted that walking had improved significantly. He was still unable to perform standing shift

correction, but could now lie prone without increased symptoms. Attempts at achieving further extension in lying resulted in a Produce or Increase / No Worse response. Various alternate loading strategies and therapist techniques were attempted without success. The client was educated that a temporary increase in symptoms was acceptable, as long as the distal symptoms did not remain worse as a result, or peripheralise. He was also informed that the ultimate goal of correction of the shift would be achieved through full restoration of extension. He was, therefore, encouraged to continue Right Rotation in Flexion, as needed, and to increase time lying prone in extension. The client was informed of the expectation that a temporary increase of symptoms would occur and to follow the rules on symptom response at all times.

Four days later, the client returned noting that he was now able to lay prone on elbows without aggravating his symptoms. He reported that the first couple of days created a temporary Increase but No Worse response, but he persisted since this was an acceptable response. He was very happy to find that he could work further toward extension in lying. We reviewed acceptable symptom responses and the goal of achieving full extension. Self-correction of lateral shift in a doorway was now tolerable, although he was only able to initiate performance in some degree of lumbar flexion. The client was sent away with attempting further extension in lying with the use of pillows (the client was unable to perform REIL secondary to an unrelated shoulder injury) and exploration of lateral shift correction in a doorway. He was encouraged to focus on achieving full overcorrection of his shift before attempting to perform lateral shift correction in more extension.

Upon each visit the client was able to demonstrate the ability to gain further range without aggravation into movements that, at his prior visit, either resulted in an increase or peripheralisation of symptoms. Therapist techniques were unsuccessful with reduction. The client was routinely educated on the expected symptomatic responses, the appropriate adjustments in the loading strategy, and the performance of his exercise as the most therapeutic intervention. By the third visit he was able to initiate self-correction of lateral shift in a doorway with slight adjustments in hip angle and by the fifth visit he was able to

perform REIS without increasing symptoms. At that time, he was further educated on the importance of maintaining lordosis, achieving end-range extension throughout the day, and ensuring that he could perform pain free SGIS to the Left several times a day. He continues to demonstrate a slight Right Lateral Shift, but it is no longer relevant and he has begun a restoration of function program in the gym to address his bilateral total knee replacements and secondary right shoulder condition (a derangement that is responding very well to patient produced forces).

DISCUSSION

This case demonstrates that, in this instance, a significant lateral shift deformity with multiple co-morbidities responded best to patient produced force progressions. At times, one will find that the desire to "speed up" the process will, in fact, only result in unwanted symptomatic responses. When we are presented with such a presentation, we must take a step back and remind ourselves that the most therapeutic loads will be those that can be self administered by the client 24 hours a day. These loading strategies may initially result in an INCREASE/NW response. A temporary increase in symptoms is not a sign to STOP a particular loading strategy. Throughout treatment, the above client would go home to explore the INCREASE/NW response and return with a clear BETTER response a few days later. Success was achieved by ensuring that the client had a clear understanding of "Why do I need to do these exercises? How do I perform them? What should I expect as a result?" By utilizing McKenzie's logical assessment process and achieving a consultative process with the client, the clinician is able to answer these three questions sufficiently so that the patient is empowered and the desired therapeutic response occurs.

Let the system be your guide.

Reference: McKenzie RA (1989). A perspective on Manipulative Therapy. Physiotherapy, 75(8), 440-444.

►► Translating MDT to payers

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With ever increasing cuts in reimbursement, we have to prove that our service is medically necessary and functionally significant through documentation. Physical Therapy is under ever increasing scrutiny by the insurance industry to justify our services and explain the functional importance through documentation.

In MDT, we have the added challenge of providing a service that has many variances in the way it is applied. Many therapists use it as a “tool” when they miss its power as the “toolbox”. By using MDT as a clinical reasoning tool, the documentation is an effective way to communicate a process that requires advanced problem solving. This is achieved by continuous reassessment to support classification for determining prognosis: the strongest selling point for the MDT method to payers.

One of our biggest challenges is educating payers as to what MDT is, and how it differs from other types of physical therapy. The only way we can effectively demonstrate this is through our documentation, which must be easy to understand. Payers do not know the person you are treating, and they have no way of knowing if you are being effective, unless you tell them. Reviewers may or may not have a PT background. Therefore, your job is to make your notes read like a story, so anyone reading them can see your logic and follow it through. This is where MDT clinicians can shine, because when done correctly, the MDT process is very simple and logical.

The following suggestions can help payers better understand the MDT method:

Subjective: Tell the story of your patients by summarizing the history portion of the MDT assessment form. Paint a picture that will answer the following questions:

- What is their age?
- What is their occupation?
- Why are they here to see you?
- How do their symptoms behave?
- What are the functional limitations?
- What are the barriers to recovery, i.e. previous treatment, surgeries, medical history, etc?

Objective: Document in a manner consistent with the McKenzie Institute and be sure to use functional baselines whenever possible during the repeated movement portion of the exam. Your argument will be much more powerful if the patient reports a change in function.

Avoid using abbreviations unless you have previously defined the term in that note. RFIL, REIL and P, W are not universally understood terms, so you must spell them out. It may take some extra time while writing the note, but it will save time and money in returned claims.

Assessment: Provides a logical conclusion from a combination of the subjective and objective. Remember, your job is to make a decision:

1. Is this person appropriate for physical therapy
2. Determine mechanical classification
3. Establish Functional Goals relating to their problem
4. Conclude prognosis along with comorbidities

Plan: The plan should be an extension of the assessment - clearly stating classification, duration and treatment, and how treating this problem should affect their functional limitations.

Choose only one intervention, so that you are able to objectively assess the effects of the intervention. Avoid the urge to treat before you have a classification, which McKenzie is careful to point out could take several visits. **If you haven't confirmed classification in 3-5 visits, refer back to the physician: this is the best selling point to the payers; so that you can demonstrate you will not overtreat.**

Each note that follows should be a mini-assessment, with emphasis on function. Ask your patient to report a percentage improvement every two weeks and assess their functional goals. Set a point of progress, i.e. 50%, and make adjustments as necessary. If the patient plateaus, it may be a sign that you either need another set of eyes, or they need to be discharged.

Meeting with the payers

If you have a relationship with a payer, start by having a conversation and explain that you want them to understand the MDT method.

In order to translate MDT to payers, we have to make sure, first of all, that we understand their needs. Payers want to save money. No matter where you go with the conversation, remember that the key for them is being able to provide the service their customers need at the lowest cost available. There are a couple of ways to achieve this goal by using a MDT provider:

1. Identifying which patients can be helped in a timely manner
2. Emphasizing patient involvement and empowerment to reduce recurrences and increasing costs for imaging, etc.
3. Classifying patients which leads to better outcomes by reducing the number of visits.

In this meeting, discuss the reliability of the method in comparison to passive treatments. Educate the payer on the importance of classification and centralization. Finally, support your conversation with research.

Remember, the care provided with a skilled MDT clinician starts with the thought process; to figure out the most effective way to take care of the patient. We are the movement experts, and it is our logical assessment of a musculoskeletal complaint that will help this person and get them back to life.

LET US HELP YOU TRANSLATE!

The McKenzie Resource Center has a wealth of information at your disposal that can help you prepare for meetings with payers.

- The MII Core Reference List is continuously updated with articles relevant to MDT. Use a quote or two from one of these articles to help drive home your point and solidify your stance.
- **Research Reviews** provides you with MDT-trained clinicians' perspective on recent, significant articles.
- Institute Members have access to the **Research Abstract Database**, which includes full abstracts as well as past articles from the IJMDT.

Any one of these options can help validate your position with payers and physicians to help inform them on how everyone benefits from MDT!

www.mckenziemdt.org/resource.cfm



THE MCKENZIE INSTITUTE LUMBAR SPINE ASSESSMENT

Date _____
 Name JB Sex (M) / F
 Address _____
 Telephone _____
 Date of Birth _____ Age 76

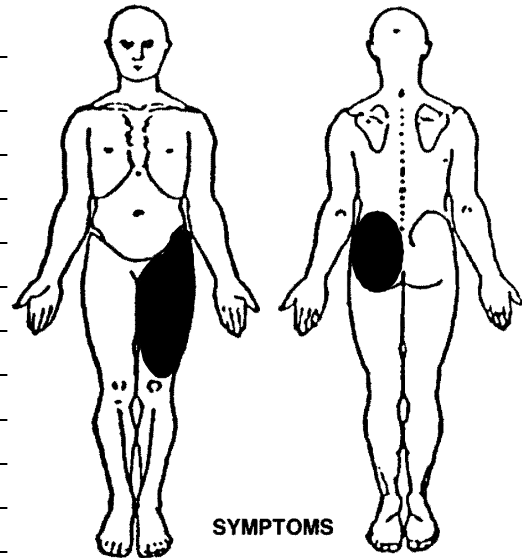
Referral: GP / Orth / Self / Other _____
 Work: Mechanical Stresses Retired, Sedentary

Leisure: Mechanical Stresses Bowling, Gardening

Functional Disability from present episode Bending, Walking

Functional Disability score _____

VAS Score (0-10) 9/10



HISTORY

Present Symptoms Left Back and Thigh

Present since 3 weeks Improving / Unchanging / Worsening

Commenced as a result of Bowling ?? Or no apparent reason

Symptoms at onset: back / thigh / leg

Constant symptoms: back / thigh / leg Intermittent symptoms: back / thigh / leg

Worse Bending Sitting / rising standing walking lying
 am / as the day progresses / pm when still / on the move
 other _____

Better Bending sitting standing walking Lying Left
 am / as the day progresses / pm when still / on the move
 other _____

Disturbed Sleep Yes / No Sleeping postures: prone / sup / side R / L Surface: firm / soft / sag

Previous Episodes 0 1-5 6-10 11+ Year of first episode _____

Previous History Bilateral TKR – lack of full Knee Extension Right

Previous Treatments None for lumbar spine

SPECIFIC QUESTIONS

Cough / Sneeze / Strain / +ve -ve Bladder: normal / abnormal Gait: normal / abnormal

Medications: Nil / NSAIDS / Analg / Steroids / Anticoag / Other Tramadol

General Health: Good / Fair / Poor _____

Imaging: Yes / No X-Ray (Stenosis and Bone Spurs)

Recent or major surgery: Yes No Night Pain: Yes No

Accidents: Yes No Unexplained weight loss: Yes No

Other: _____

EXAMINATION

POSTURE

Sitting: Good / Fair / Poor Standing: Good / Fair / Poor Lordosis: Red / Acc / Normal Lateral Shift: Right / Left / Nil
 Correction of Posture: Better / Worse / No effect ↑ Back, Produce Thigh Relevant: Yes / No
 Other Observations: _____

NEUROLOGICAL

Motor Deficit _____ Reflexes _____
 Sensory Deficit _____ Dural Signs _____

MOVEMENT LOSS

	Maj	Mod	Min	Nil	Pain
Flexion			X		
Extension	X				Left Thigh
Side Gliding R			X		
Side Gliding L	X				Left Thigh

TEST MOVEMENTS Describe effect on present pain – **During:** produces, abolishes, increases, decreases, no effect, centralising, peripheralising. **After:** better, worse, no better, no worse, no effect, centralised, peripheralised.

	Symptoms During Testing	Symptoms After Testing	Mechanical Response		
			↑Rom	↓Rom	No Effect
Pretest symptoms standing: Back					
FIS					
Rep FIS					
EIS	3. Increase Thigh				
Rep EIS	Increase Thigh	W			X
Pretest symptoms lying:					
FIL					
Rep FIL					
EIL					
Rep EIL					
If required pretest symptoms:					
SGIS – R					
Rep SGIS - R					
SGIS – L	1. Increase Back, Produce Thigh				
Rep SGIS- L	Increase Thigh	NW			X

STATIC TESTS

Sitting slouched _____ Sitting erect _____
 Standing slouched _____ Standing erect _____
 Lying prone in extension **4. Increase / Worse** Long sitting _____

OTHER TESTS 2. Manual Shift Correction = Produce Thigh/ Worse , No Change in ROM
5. Right Rotation in Flexion = Decrease Back and Thigh / Better, able to ambulate better

PROVISIONAL CLASSIFICATION

Derangement Dysfunction Posture Other
 Derangement: Pain location **Asymmetrical Above Knee with a Lateral Shift Deformity**

PRINCIPLE OF MANAGEMENT

Education Centralisation & Symptom Response Equipment Provided _____
 Mechanical Therapy: Yes / No _____
 Extension Principle: _____ Lateral Principle: _____
 Flexion Principle: Right Rot in Flex x 5-10 min / hr Other: _____
 Treatment Goals: Correct Shift; Ambulate without limitation; Return to IADL's and Bowling