

# moving in the right direction

Mechanical Diagnosis And Therapy®  
of the spine and extremities

## ►► Fraud & Abuse in Physical Therapy: Are you at Risk?

Stephen M. Levine, PT, DPT, MSHA

Most of us don't wake up each morning thinking and plotting about how we are going to defraud the federal government – in fact, the vast majority of physical therapists love what they do, and go to work every morning thinking about the positive impact they make on their patients and the communities they serve. However, over the past decade, the health care environment has changed. Health care providers, including physical therapists, are working harder and spending longer hours in the clinic - swamped with paperwork in addition to the direct patient care responsibilities they have - while seeing less and less payment for the services they provide. It is all many can do to keep up with the things that have to get done during the day, and it is no wonder that so many therapists do not have time to spend keeping current with all the rules related to participation in the US health care system.

However, the penalties for not paying attention to and following the rules have become too big to ignore. Health care in general, and physical therapy specifically, has become a target for audit and investigation in order to minimize fraud, waste, and abuse in the healthcare system, particularly in the Medicare and Medicaid systems. **Fraud** is defined as *"Knowingly and willfully executing, or attempting to execute a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program."* Those who fall in this category are few - and they should be punished appropriately, and frankly deserve what happens to them.

But there are far more physical therapists who fall into the category of **Abuse**, 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."* Unfortunately, the likelihood that physical therapists are committing abuse, without even knowing it, is fairly great.

Most do not realize that many of the current fraud and abuse activities originated with the adoption of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Although health care providers tended to focus on the privacy portion of the law, HIPAA has two main goals, as its name implies: 1) Making health insurance more portable when persons change employers, and 2) Making the health care system more accountable for costs – trying especially to reduce waste and fraud. Further, HIPAA makes "knowingly and willfully" defrauding any health care benefit program a federal crime, and includes making false statements "in any matter involving a health care benefit program," theft or embezzlement, obstruction of investigations, and money laundering a federal crime as well.

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. 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**

This newer definition of "knowing", if not a criminal violation, may in fact place the physical therapist at significant financial risk. Recently the Office of Inspector General (OIG) published two reports, one related to a physical therapist in Florida (services provided in 2003) and another in Texas (services provided in 2002). Published in August and December of 2007 respectively, these OIG reports identified incorrect use of provider numbers, documentation problems, incorrect CPT coding, Plan of care insufficiencies, and lack of medical necessity as the key elements of the investigation. These investigations resulted in refund requests of \$411,781 and \$281,325 respectively in claims erroneously paid to these providers. Of note, the OIG concluded the same thing in both cases:

***"The physical therapist did not have a thorough understanding of Medicare requirements and did not have effective policies and procedures in place to ensure that he billed Medicare only for services that met Medicare reimbursement requirements"***

The words "fraud" or "abuse" were never directly stated in the OIG report, but the findings are nonetheless potentially devastating to these physical therapists. These reports, in addition to the many other situations that occur regularly, demonstrate the criticality of the issue and the necessity for physical therapists to learn about the rules that govern the coding, billing, and documentation of our services, and ensure they keep current with the regulations that govern our practice so that risk for violation of these rules can be minimized. **Remember, ignorance of the law is no defense!**

**Join Steve Levine July 25th  
for a Pre-conference Seminar in Orlando, FL!**

*Receive valuable information on how to minimize your risk of violation of the "rules of engagement" when seeing patients under the Medicare program or private payers!*

For details & registration visit:  
<http://www.mckenziemdt.org/conf2008-6.cfm>

### In This Issue:

- Guest Commentary
- Case Study
- Research Spotlight
- Business Corner



## ►► Confidence Through MDT ListServ Mentoring

Sean Gupta, PT, Cert. MDT

Help! Torticollis – First Patient Ever

### Initial Examination: March 20/08

Please refer to the full completed assessment form posted in [this issue](#) on our website via the MDT Resource Center.

A 17 year old male with complaints of bilateral neck pain (right worse than left) that started a few hours after lifting heavy boxes. Pain slowly worsened that evening and he awoke the next morning with a torticollis (left side flexion with slight right rotation). I am now assessing him about 4 weeks after onset. He reports the pain is constant on the right side and intermittent on the left and that it has been unchanging since this happened. He denies any other symptoms and no other previous history of neck pain.

As I have never had a torticollis before, all I could remember from my McKenzie courses and The Cervical and Thoracic MDT textbook was that a torticollis could only be corrected in supine. I also remember hearing that a torticollis was easy to correct in younger patients with many achieving full reduction upon the first visit. Because this was my first torticollis patient and I wasn't confident with how to proceed, I decided to post a message to the online MDT study group to get some help after the initial visit.

### Follow-up appointment #1: March 25/08

Patient reports no significant change in his pain intensity. He reports performing the prescribed exercise once per day for about 20-30 minutes. He would get an increase in pain that would not worsen when he tried to correct the deviation.

On exam, his head is still held in left side flexion, but not as much as it was before (perhaps slightly better but not significant). There is no significant change in his symptoms or ROM.

From the MDT study group, it was apparent that I may have rushed the reductive process and that I should have started with side flexion instead of rotation to correct the deformity. Here are some of the comments and suggestions I received from the MDT study group:

*"From my experience, correction of torticollis usually takes at least 30-45 min. So patience and sufficient explanation to the patient is very important." -- P. S.*

*"...they don't really improve unless you get at the side bend part of it. Start with one pillow in the position of comfort and wait 3-5 minutes. Passively move the head about one half or an inch to right and wait 3-5 minutes (maybe add some intermittent rotations to the right or retractions depending on irritability). Then, move the head another inch, wait another 3-5 minutes and so on. Once they are past neutral, they can usually start using the right hand on top of head to self slide that inch further into right side flex. Once you can get him to full right side flexion with overpressure (that day or the next), perform retractions off the bed. If that goes well, then do retraction plus extension." - A. L.*

I followed the advice given above to correct the deformity by slowly bringing him into right side flexion, holding for a few minutes, and then continuing to go further. After about 20 minutes of doing this, the patient told me that the pain was increasing and therefore we eased up and let him relax back into the deformity.

I further questioned him about the increase in pain response when we tried to correct the deformity. I decided to use a VAS scale to quantify his subject complaints (not sure why I didn't think of this before). He said that the resting pain was 8/10 and that attempting to right side flex made the pain 8.5/10. I decided that this was such a minor increase in discomfort that I would get him to push into it.

We started the same procedure again but this time monitoring his pain level. Upon beginning to right side flex the pain increased from 8/10 to 8.5/10 but then remained here the whole time. After only 5-6 minutes, we were slowly able to get him into full RSF with his ear touching his shoulder (I couldn't believe it!).

I told him to do right side flexion with self overpressure. After a few seconds of sustaining the overpressure, the pain went down to 7/10. Then a few seconds later, the pain went down to 4/10, then 2/10, and eventually it abolished.

I held him in the overcorrected position, and slowly removed the pillows. Then, I returned his head to neutral. During this time, the pain still remained abolished.

We did two sets of 10 retractions off the end of the bed which appeared very easy for him to do. This was followed by two sets of 6 retraction-extensions. The pain still remained abolished.

I repositioned him into sitting. All of his pain was now abolished and he had full right rotation and right side flexion.

I instructed him to do RSF in sitting 10 times every two hours and to check his posture regularly as he had a tendency afterwards to want to go back into LSF (perhaps this was because he had been left side flexed for 4 weeks now and he had become used to it).

### Follow-up appointment #2: March 27/08

Patient was unable to attend for the remainder of the week so a telephone follow-up was done today. I was told that he no longer had the torticollis after leaving the last appointment. He had been doing the exercises occasionally but had resumed normal activity. He was now complaining of a very slight left-sided headache but he wasn't too concerned about this as this usually comes and goes. He was instructed to call in the next 2 weeks if anything happens or he doesn't continue to improve.

As of April 14/08, I did not hear from him and so his chart was discharged and closed.

### Discussion

Having never had a torticollis patient before, I found it very easy to get help by posting on the MDT study group. What we have in MDT is a standardized way of talking which makes it easier to communicate to one another. By following the advice given to me by my colleagues and by paying attention the patient's symptomatic and mechanical response (red, amber, and green lights), I was given the confidence to know when to apply force alternatives and progression of forces.

It should be noted that no manual techniques were needed to reduce this derangement although on the MDT study group (as well as in the Cervical & Thoracic MDT books), it was suggested that manual techniques may be needed to correct a torticollis.

I would encourage you all to use the MDT study group to post questions, respond, and even to provide case studies as we can all benefit from each other's experience.



## ►► Reconceptualising pain according to modern pain science

G. Lorimer Moseley

Reviewed by Charles Sheets, PT, Dip. MDT

This article presents a summary of several decades of progress in our understanding of pain and its treatment, moving from the well-known gate-control theory to the current description of the pain neuromatrix. The neuromatrix theory views pain as one of multiple outputs of the central nervous system that occur when tissues are seen to be under threat; it can be accompanied by changes in the immune system, as well as changes in muscle activity. This pain response, however, is related to the perceived threat of damage to the tissues, not to the actual level of tissue damage, especially in patients with more chronic pain. This helps to explain the significant impact that psychosocial factors have in establishing and maintaining chronic pain states.

This paper makes four primary points: pain does not provide a direct measure of the state of the tissues, pain is modulated by many factors from across somatic, psychological and social domains, that the relationship between pain and the state of the tissues becomes less predictable as pain persists, and that pain can be conceptualized as a conscious correlate of the implicit perception that tissue is in danger.

Given this understanding, the author emphasizes the need for diagnosis and treatment skills beyond anatomy and biomechanics as emphasized in such systems as Mechanical Diagnosis and Therapy. The clinician must recognize that peripheral and central sensitization, as well as psychological and social factors will all have an influence on the patient's perception of the threat to their tissues. Given the wide and rapidly growing literature on this topic, however, it would be impossible for all but the most dedicated to be current in all aspects of pain understanding. The clinician is emphasized, rather than knowing all of the evidence, to consider different psychological and social factors in terms of what effect they might have on the patient's perception of threat. Patient education about pain biology has been shown to have immediate and lasting effects on pain and disability. The goal of education is to understand the different factors affecting pain, and encourage patients to ask "how does this [factor] affect the answer to this question, how dangerous is this really?"



Physical Therapy Reviews 2007; 12: 169–178  
To access the article abstract, visit:

<http://www.ingentaconnect.com/content/maney/ptr>  
(Volume 12, No 3, Sept 2007)

In addition to addressing these factors, physical treatment is designed to encourage a return to normal movement, without provoking excessive protective responses. This involves setting a safe baseline, and then exposing the tissue gradually to threat while avoiding unwanted symptom response. This is consistent with the general treatment outline for "chronic pain syndrome" patients in the McKenzie and May lumbar text, which discusses graded exposure and general movement, without a focus on direction-specific treatment. The book discusses that the priority for MDT therapists is a thorough mechanical evaluation and re-evaluations, recognizing that a general worsening of symptoms with all movements likely indicates a non responder due to a chronic pain state. Length of time since onset, while an aspect of the diagnostic reasoning, is not sufficient in isolation to justify this classification.

Since reading and incorporating into my practice the ideas presented in Lorimer Moseley's "Explain Pain" and "Painful Yarns" books, as well as "The Back Book", I have seen a marked change in my relationships and outcomes with patients with chronic pain. Those who have never had the opportunity to learn this information before will often immediately "get it", with rapid and occasionally instantaneous changes in pain level. They are frequently relieved to finally understand why this pain remains, and on multiple occasions patients who did not appear to fit any specific category will, with a greater understanding, be able to better describe their pain response and subsequently fit a mechanical classification. The ideas presented in these books and related research have had the greatest impact on my treatment over the past several years.

**Don't miss the chance to hear Lorimer Moseley at the MDT Conference of the Americas – Limited Seats Remain!!! Register today at [www.mckenziemdt.org/conf2008.cfm](http://www.mckenziemdt.org/conf2008.cfm)**

## ►► What Do The McKenzie Brand And Coca-Cola Have In Common?

By David C Steinberg, CEO Marketing Turnkey Systems and PTreferralMachine.com. May, 2008. ©

Branding is an important job. Done well, it has the power to efficiently attract customers; done poorly, you may pull your hair out in frustration.

Branding is a systematic way of communicating value. Each industry has different values that are important to customers. With soft drinks, for example, the primary appeal is social emotional. And because of the importance of the social emotional component for Coke, they need to frequently update their slogan every few years to keep the appeal fresh. For Coke, the passing of time has taken the company through 47 slogans, from its original slogan in 1886, "Drink Coca Cola," to "The Coke Side of Life" launched in 2006. Coke has a track record of responding quickly to trends, sometimes too quickly, as happened with the disastrous launch of "America's Real Choice" and New Coke in 1985. Fortunately for a brand like McKenzie, which is sold based on concrete results and evidence, not social appeal, changing slogans is not quite that important.

At this point you should be wondering what this has to do with you and McKenzie. After all, marketing soft drinks is a bit afield from marketing McKenzie, right? Well not really. The principles are the same. So let's get to it.

With a little help from Coca Cola's former Chief Marketing Officer, Sergio Zyman, we can learn how to leverage powerful branding principles to increase the frequency by which prospective patients and referral sources select Coke (I mean McKenzie), as the preferred brand.

CONTINUED ON PAGE 4

Sergio's Branding Principles\*

A brand is a container for a customer's complete experience with a product and company.

A brand simplifies the buying process by differentiating a product on something besides price.

A brand is the bundle of functional and emotional benefits, attributes, usage experiences, icons, and symbols that in total comprises the meaning of a product or service.

A brand is a company's most valuable asset.

Branding is the conscious strategy and action of turning a product or service offering into a brand.

MDT Application

Make the experience as unique and memorable as possible. Ask yourself, what can I do to make each visitor or referral source say, "Wow, that exceeded my expectations."

MDT is unique, and gives you clearly differentiable skills, but to our prospect, clinic visitor, or referral source, they probably view your approach as typical. You need to fix that, by providing more than just information on what to expect during visits. Comparisons work well here – they help your prospects understand the basic treatment differentiators so they can explain to a friend or colleague why what you do is special, unique, and more effective than other options.

Don't create patients, create MDT consumers.

MDT is an international network. The sheer size, scope, and composition of the network are a very powerful branding weapon. How do you make this information visible to prospective patients and referral sources? Provide tangible evidence, in simple to understand tools or handouts. Create special pages and forums on your website, and SHOWCASE them wherever possible. Reinforce benefits repeatedly with additional evidence in the form of articles and reports. Well designed professional handouts add credibility to the brand. Implement a proactive testimonial and referral program.

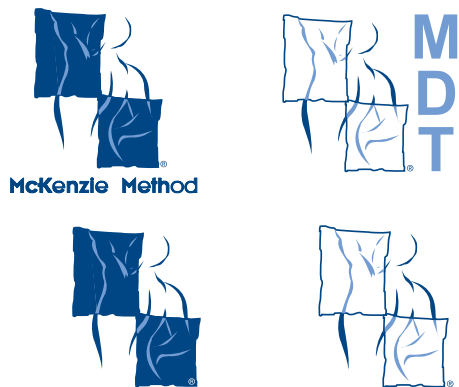
Effective communication of the brand to your target audience makes the job of generating visits infinitely easier.

There is nothing with the potential return on investment more powerful than a well managed brand.

Communicating important and relevant information to your prospective patients and referral sources should be systematized right down to the very last detail. How is the phone answered? What do you send potential referral sources, and how often? What low risk trial offers do you promote and advertise? How do you train your associates to use all these tools and understand your strategy?

\*As written in Sergio Zyman's book, "The End Of Advertising As We Know It", John Wiley & Sons, © 2002

So how do you tackle this? The very first step is easy. Make sure all your materials include a consistent use of the McKenzie trade mark.\*\* As the MDT process becomes familiar to your prospective patients and referral sources through your other marketing activities as described in the table above, the trademark becomes an INSTANT handle for the special "container" known as McKenzie.



◀ MDT Consumer Brochure (can be customized)

\*\*Use of the McKenzie materials and trademarks are restricted to those certified in MDT who are active members. Logos and brochure details can be accessed via the Resource Center on our website.

If this is done well, through time and exposure, you become an integral part of that container, and with little thought, McKenzie consumers will choose you. If you're concerned that promoting a brand like McKenzie may interfere with your own company identity, you may want to rethink that. Associating with strong brands can have great business benefits – that's the point of *brand equity* –it's valuable, USE IT. Can you imagine a Coca Cola distributor leaving the trademark in the draw? Of course not.

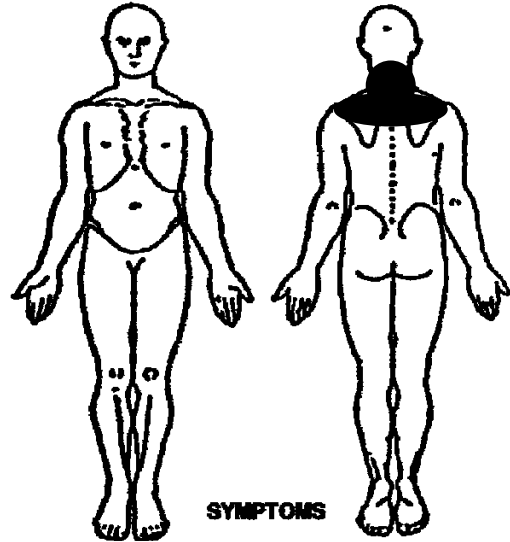
If you're doing this on your own, pick one principle from the table and master it. Create materials with consistent design elements and use of the trademark. If you can afford a basic budget, get help from a professional marketing company that understands your unique branding challenges.

To get a better idea about what to look for in your marketing company, download our complimentary Clinic Owner's Guide To Marketing at [www.PTreferralmachine.com](http://www.PTreferralmachine.com), or attend one of our webinars. See the webinar content description at [www.PTreferralMachine.com/webinar](http://www.PTreferralMachine.com/webinar).



# THE MCKENZIE INSTITUTE CERVICAL SPINE ASSESSMENT

Date March 20/08  
 Name Mr. H Sex M / F  
 Address \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age 17  
 Referral: GP / Orth / Self / Other \_\_\_\_\_  
 Work: Mechanical stresses \_\_\_\_\_  
 \_\_\_\_\_  
 Leisure: Mechanical Stresses \_\_\_\_\_ student  
 Functional Disability from present episode \_\_\_\_\_  
 \_\_\_\_\_  
 Functional Disability score \_\_\_\_\_  
 VAS Score (0-10) \_\_\_\_\_



## HISTORY

Present Symptoms central neck & shoulder pain with right side much worse than left side  
 Present since 4 weeks Improving / Unchanging / Worsening  
 Commenced as a result of awoke next am after lifting heavy boxes night before / Or no apparent reason  
 Symptoms at onset: neck / arm / forearm / headache \_\_\_\_\_  
 Constant symptoms: neck / arm / forearm / headache Intermittent symptoms: neck / arm / forearm / headache  
 Worse bending sitting turning lying / rising  
am / as the day progresses / pm when still / on the move  
 other \_\_\_\_\_  
 Better bending sitting turning lying  
am / as the day progresses / pm when still / on the move  
 other \_\_\_\_\_  
 Disturbed Sleep Yes / No Pillows 1 or 2  
 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 this is his first episode of neck pain

Previous Treatments none

## SPECIFIC QUESTIONS

Dizziness / tinnitus / nausea / swallowing / +ve / -ve Gait / Upper Limbs: normal / abnormal  
 Medications: Nil / NSAIDS / Analg / Steroids / Anticoag / Other \_\_\_\_\_  
 General Health Good / Fair / Poor \_\_\_\_\_  
 Imaging: Yes No \_\_\_\_\_  
 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 Protruded Head: Yes / (No) Wry Neck: Right / (Left) / Nil  
 Correction of Posture: Better / Worse / No effect did not assess Relevant: (Yes) / No  
 Other Observations: \_\_\_\_\_

**NEUROLOGICAL**

Motor Deficit Not assessed Reflexes Not assessed  
 Sensory Deficit Not assessed Dural Signs Not assessed

MOVEMENT LOSS	Maj	Mod	Min	Nil	Pain
Protrusion	X				X
Flexion	X				X
Retraction	X				X
Extension	X				X

	Maj	Mod	Min	Nil	Pain
Lateral flexion R	X				X
Lateral flexion L				X	
Rotation R	X				X
Rotation L		X			X

**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
<b>Pretest symptoms sitting:</b>					
PRO	/				
Rep PRO					
RET					
Rep RET					
RET EXT					
Rep RET EXT					
<b>Pretest symptoms lying:</b> Right sided neck pain					
RET	-patient was positioned in supine with 1 pillow. Over				
Rep RET	15 minutes, I tried shift correction using right rotation				
RET EXT	and had him try to sustain it – response was increase,				
Rep RET EXT	NW. Then I tried right side flexion, again with the				
<b>If required pretest pain sitting:</b> same response. I tried changing					
LF - R	the angle of the pillows, but that didn't work. Then I				
Rep LF - R	tried lying him on his right side with many towels				
LF - L	underneath his head to accommodate the deformity				
Rep LF - L	and tried to correct the shift this way by slowly				
ROT - R	removing towels – this did not work either.				
Rep ROT - R					
ROT - L					
Rep ROT - L					
FLEX					
Rep FLEX					

**STATIC TESTS**

Protrusion \_\_\_\_\_ Flexion \_\_\_\_\_  
 Retraction \_\_\_\_\_ Extension: *sitting / prone / supine* \_\_\_\_\_

**OTHER TESTS** \_\_\_\_\_

**PROVISIONAL CLASSIFICATION**

(Derangement) Dysfunction Postural Other  
 Derangement: Pain Location unilateral asymmetrical above elbow with torticollis contralateral shift

**PRINCIPLE OF MANAGEMENT**

Education: how to correct torticollis Equipment Provided: \_\_\_\_\_  
 Mechanical Therapy: (Yes) / No to perform sustained right rotation in supine and to try to correct past midline as above  
 Extension Principle: \_\_\_\_\_ X \_\_\_\_\_ Lateral Principle: \_\_\_\_\_  
 Flexion Principle: \_\_\_\_\_ Other: \_\_\_\_\_  
 Treatment Goals: resolve torticollis, decrease pain, increase ROM. To follow up in 5 days.