CHAPTER 6

Documentation: Session Notes

After mastering the concepts in this chapter, the student will be able to:

- Produce session notes that include information representing all four major categories of a SOAP (Subjective, Objective, Assessment, Plan) chart
- Produce specific, comparative measures for subjective and objective data
- Apply abbreviations for medical terminology used in charting
- Integrate functional outcomes reporting into session notes
- Carry out charting in the session with the patient to ensure patient-centered care and patient-identified goals for care

Zamora Hostetter, a 24-year-old woman, has a severe shoulder injury. She cannot use her right arm at all owing to a complete shoulder separation. She slipped on a banana peel while carrying a 25-pound bag of rice. The bag fell on top of her, magnifying the impact of the humerus into the AC (acromioclavicular) joint and increasing the severity of the injury. She has concomitant symptoms: headache, neck stiffness, and back pain. She was taken to the emergency room and released the same day. She went to see her mom's chiropractor the next day and was referred to Helena LaLuna for watsu (water shiatsu) until Zamora regains her mobility and fascial and structural balancing.

Ms. Hostetter is a very motivated, young, healthy woman who is eager to get back to her active lifestyle. She has clear goals and can articulate them, with their assistance, to her chiropractor and massage therapist and use as functional goals for the treatments. She is used to riding her bike everywhere, has regular stretching and strengthening routines, and is frustrated relying on bus transportation to get to her appointments. This has not stopped her from being on time to every appointment. However, she is challenged by the strict

requirements to avoid all lifting and wear a sling to prevent further injury and remind her to avoid using her right arm at all.

Helena knows how difficult it is to get approval for manual therapist from workers' compensation. The first six appointments are standard, but beyond that, she must demonstrate severity of injury and necessity for the type of treatment she is providing. Knowing that her time with Zamora may be limited, she creates a treatment plan for the series of six sessions, modifying it as their goals for care are reached. That and thorough charting of every treatment session, including pre- and postoutcome measures, increased her ability to obtain preauthorization for two additional sets of six sessions each!

Introduction

Note taking is an important component of every health care session. **SOAP charting** has been a standard format for documenting treatment sessions in the health care field, routinely used by physicians, physical therapists, chiropractors, nurses, manual therapists, and other medical and allied health professionals.[1] With the onset of electronic health records (EHRs), the SOAP format is less useful. Content can be prompted by detailed section headers and separated by pages rather than format headers, such as subjective and objective. However, the SOAP format is still useful for providing simple and flexible structure for taking notes on paper. As a result, we will refer to the SOAP format as a teaching tool, and promote its use for paper health record keeping.

The SOAP chart documents the patient's health information and goals, the practitioner's findings and treatment, and the patient's self-care routine; moreover, it records the patient's response to the solutions and progress toward the goals. The information is organized into four categories:

- **S**ubjective—data provided by the patient (symptoms and functional limitations)
- **O**bjective—data from the practitioner's perspective (movement tests, palpation findings, and visual observations, as well as treatment and the patient's immediate response to the treatment)
- **A**ssessment—functional goals and outcomes based on activities of daily living
- **P**lan—treatment recommendations and self-care education

This structure prompts comprehensive information gathering and makes data storage and retrieval easy.

Adaptations of the SOAP format have been created for massage therapists, for example, SFTRO[2] and CARE.[3] This chapter provides basic information for manual therapists on how to use the traditional SOAP format with a focus on **functional outcomes reporting**. Some clinics, hospitals, and schools may require a standard of documentation that varies slightly from that presented here; however, the skills acquired through this book can be adapted easily to suit any system of documentation, especially EHRs. When massage therapists master the basics most common to all health care providers, the transition will be easy when an employer requires another format or adopts an EHR or the therapist chooses something more appropriate for his or her needs. For example, SOAP charting can be adapted into the CARE format, which is noted as follows:

- **C**ondition of the patient—measurable data regarding the patient's medical condition, such as pain or tension (split between the subjective and objective sections)

- **A**ction taken—types of massage provided, location, and duration of treatment (part of the objective section)
- **R**esponse of patient—measurable physiological changes and verbal and nonverbal feedback (part of assessment; however, proponents of CARE charting do not advocate using the functional outcomes style of reporting; this is conceivable if your patients are relatively healthy and without functional limitations)
- **E**valuation—recommendations for future treatment, such as massage, patient homework, and suggestions to other caregivers (plan)

In a Canadian workbook titled *Charting Skills for Massage Therapists* by Donald Quinn Dillon, RMT, the following structure (SFTRO) is recommended:

- **S**ymptom picture (includes history and presenting conditions)
- **F**indings, **T**reatment, **R**ecommendations (objective data, treatment applied, self-care, referrals and treatment plan for the future)
- **O**utcomes/notes (changes to findings posttreatment)

Again, the categories used in this text encompass the basic content of a SOAP chart using a slightly different format. It is important to recognize that many formats are available, and all are permissible in the health care arena, as long as these components are present: patient condition/symptoms, patient goals for treatment, practitioner findings (pre- and posttreatment), care provided, and future care recommendations. Learn to gather the necessary information, measure it, record it, note progress by it, and care for the information according to privacy standards.

The advantages of using the SOAP format include the following:

- Consistency across professions
- Common language and communication style
- Demonstration of professionalism
- Proof of progress and **functional outcomes**
- Brevity and comprehensiveness
- Fast retrieval of information

A more universal trend in documentation is functional outcomes reporting. This style of charting—writing notes that address the patient's ability to function in everyday activities and setting goals and designing treatments to improve function—has quickly been adopted by physical therapists and massage therapists alike and are even required reporting from physicians by insurance companies. This fits into the integrative health care movement toward patient-centered care. Functional outcomes reporting fits into the SOAP format and shifts the focus of documentation to the patient's quality of life. The practitioner records the patient's functional limitations and works with the patient to develop goals for returning to personally meaningful activities, and together, the practitioner and patient implement solutions to reach those goals. Because this style of recording information is patient focused and relies less on the diagnostic capabilities of the practitioner, it is a natural addition to the charting regimen for manual therapists and is therefore emphasized in this book.

TALES FROM EXPERIENCE

The Importance of Writing Treatment Notes

A medical director of an insurance carrier in Idaho was questioned by a group of manual therapists, asking why massage therapy wasn't a covered benefit in any of his plans. He replied with this: If every manual therapist can show me 6 months of session notes on every patient, we will consider it.

Guidelines for Charting

First and foremost, charting should contribute to the therapeutic relationship, not detract from it. Don't let charting become a distraction. Follow the patient's lead in the interview.[4] You do not need to follow the SOAP format in order. The beauty of the SOAP structure is that you can organize your information in a linear fashion without having to think or speak in a linear manner. As information is presented, place it in the appropriate section.

Be attentive and maintain good listening skills, as discussed in Chapter 1, Communication and the Therapeutic Relationship. If the patient is emotional and needs your undivided attention, record the information a few minutes later. It is more important to be attentive to the patient in a moment of need than to write on the chart. Reflect your understanding of the patient's experience after he or she is composed and record the data appropriate to his or her health concern once he or she verifies the information.

Be brief. Jot down just enough to jog your memory later, such as words, dates, or short phrases.[5] It can be difficult to discern important information about the patient's health as you are listening to his or her story. Things often make more sense later, after you have heard the whole story. Take brief notes and fill in the blanks after you summarize the pertinent information to the patient and get confirmation of your interpretation. This is especially easy to do in an EHR: simply edit the notes at the end of the session or at the end of your day, and lock the note when it is complete. Make sure you accurately represent the patient's concerns.

Measure everything. Gather as much detail as possible to document the injury or health concern and write it down. It is difficult to prove progress when there is nothing to mark progress against. For example, pain may still be present but diminished, occurring less frequently, with a shorter duration and fewer exacerbations than at the previous session. Be thorough and go beyond the pain and activity scales: add frequency and duration to your intake inquiry. If information is worth writing down, it is worth measuring.

Avoid vague statements. It is not enough to write "feeling better," "condition is improved," or "pain increases with sitting." Be specific. Rate the intensity of pain, describe the activities that are limited, and state how long the patient is able to perform the activity before the symptoms increase or the activity must cease. Use measurable data to explain the symptoms and compare the symptoms with those from the previous session to demonstrate progress. For example, mild pain (1, 2, or 3 on the 0–10 scale), intermittent, increasing to moderate pain with sitting for 1 hour or more expresses a decrease in pain when compared with last week's session note: moderate pain (4, 5, or 6 on the 0–10 scale), constant, unable to sit for 30 minutes or more. The information should be able to stand alone. "Feeling better" is not only vague but can also be taken out of context and can signal to an insurance company to discontinue care because the patient no longer requires treatment.[5] If the patient is feeling better, the insurance company could determine that he or she no longer requires treatment.

Use consistent terminology to measure your findings and patient symptoms, such as mild, moderate, or severe. It is difficult to note progress when comparing "hurts pretty bad" to "kinda sore" or "sorta achey." If you are unclear about the best term to use that fits the patient's symptoms, use the following guidelines:

- Normal (0 out of 10) should be noted when a symptom is resolved.
- Mild (1, 2, or 3 out of 10) describes the severity of a symptom but that the symptom does not interfere with the patient's ability to function.
- Moderate (4, 5, or 6 out of 10) describes the severity of a symptom, and as a result of that symptom, the patient is forced to modify daily activities.
- Severe (7, 8, or 9 out of 10) describes the severity of a symptom, and as a result of that symptom, the patient is unable to perform some activities of daily living.
- Disabled or bedridden (10 out of 10) is reserved for patients who are unable to function normally in any area of life as a result of the symptoms.

Chart only information applicable to the patient's condition and goals for health. Often, a story surrounds pertinent details. Pay attention to the details of the story, but be selective when choosing the information to document. Record only data that substantiate the concern or contribute to the solution. For example, Lin experiences an increase in allergies at work when Sally, a coworker from marketing, wears heavy perfume. It is not important to mention information about work or the coworker. The important thing to note is that Lin's allergy symptoms increase when she is exposed to perfume.

Be objective. State everything in a factual manner. Leave your opinions off the chart. For example, omit: "I believe the patient doesn't want to get better and is avoiding going back to work." Instead, quote the patient directly in the subjective section. The patient may comment on the situation in ways that adequately represent his or her state of mind, opinions, or emotions. Chart specific, measurable information and let his or her lack of progress, as an example, demonstrate that the treatment is not producing results. The information should pertain to the patient, not to you.[5] If the relationship isn't productive, step up the communication and reconsider your approach (review discussion of this topic in Chapter 1, Communication and the Therapeutic Relationship).

As you ask the patient specific questions to confirm an assessment or rule out a particular condition, record the positive and negative findings. Negative findings include "All active cervical ranges of motion (ROMs) normal …." The positive finding includes "…except left lateral flexion—moderately limited with mild pain at tissue stretch." If the negative findings are not recorded, it will be difficult to remember 30 days later, at the reevaluation session, which ROM tests were done at the initial assessment.

Consider another example in which "no" answers are as important as "yes" answers: Jose has shoulder pain. The pain increases when he raises his arm to the side, but there is no pain with any other shoulder movement. If you are identifying a rotator cuff injury or determining bursitis versus tendonitis, knowing that there is no pain with a particular action could affect your treatment plan as much as knowing that there is pain with an action. Record all answers that contribute to the case. Even if your scope of practice does not permit you to state on your session note whether the patient has bursitis or tendonitis, the information is critical to your treatment plan—bursitis and tendonitis are treated very differently. State only that there is pain with all ROMs, not that the patient has bursitis unless you have diagnostic scope and can treat accordingly.

Use common medical terms and become fluent with standard abbreviations (see online, Appendix D). Many standardized medical abbreviations and symbols used by all

types of health care providers are applicable to manual therapy. The medical terms referred to here are descriptive, not diagnostic. Use terms familiar to the health care community to describe your findings, such as hypertonic (HT), spastic (SP), fibrotic (fib), ischemic (IS), rather than tight, lumpy, ropey, or mushy. Use the shorthand available for these terms to make charting quick and easy.

REFINE YOUR SKILLS

Exercise: Translation

Headache pain, pounding, left frontal, moderate minus, 2–3 days, monthly, with menses for 10 plus years.

Abbreviation: HA℗, pounding, Ⓛ frontal, M–, 2–3 day/mth, c̄ menses 10+ yr.

The trigger point was moderately painful with digital pressure at the trigger point site and mildly painful at the referral site.

Abbreviation: TP M ℗ c̄ dig. pres. @TP site & L ℗ @ ref. site.

Cervical flexion passive range of motion was limited moderate minus with mild pain at end range.

Abbreviation: Cflex P–ROM↓M– c̄ L ℗ @ end range.

Right shoulder active abduction moderate segmented movement occurred with mild compensational shoulder elevation at end range.

Abbreviation: ®sh-abd A-ROM M seg c̄ L comp. sh-elev @ end range.

Moderate trigger point site pain changed to mild pain, mild referred pain changed to no pain.

Abbreviation: TP site M ℗ Δ L ℗, L ref. ℗ Δ ℗.

Moderate segmented movement in right shoulder active abduction changed to smooth movement without compensational shoulder elevation.

Abbreviation: M seg. mvm't ®sh-abd A-ROM Δ WNL s̄ comp. sh-elev.

Patient supine, anterolateral view, deep inhalation, mild plus mobility restriction upper right.

Abbreviation: pt supine, ant-lat view, deep inhal., mob L+ restr. upper®.

Left biceps insertion moderate pain with mild digital pressure, mild plus referred pain into left elbow.

Abbreviation: Ⓛ biceps insert. M ℗ c̄ L dig. pres., L+ ref. ℗ → Ⓛ elbow.

1-hour full-body Swedish massage; 30-minute foot reflexology; or 90-minute Hellerwork—inspiration.

Abbreviation: 1 hr FB Sw Ⓜ; 30 min foot reflex.; 90 min HW—inspir.

Muscle energy with cervical flexion, direct pressure on scalene trigger point, myofascial release on diaphragm.

Abbreviation: MET c Cflex, DP scal. TP, MFR diaph.

Craniosacral therapy with attention to the thoracic cage, muscle energy for cervical flexion and extension, and lymph drainage for upper quadrants.

Abbreviation: CST T cage, MET Cflex & ext, LDT UQ ℞.

Add personalized abbreviations to the list of standard ones to meet the needs of your practice. Do not use abbreviations that are not on your list, even if they are abbreviated words that you believe are common, such as quads for quadriceps muscles or hams for hamstring muscles. Others who read the patient file must be able to interpret

everything on the chart with accuracy. Payment of your bill may depend on a claims representative understanding your notes. If you use a series of tests or treatment techniques that do not have standard abbreviations, create your own shorthand and produce a legend to attach to the standardized list. For example, many of Sari's patients have been in motor vehicle collisions (MVCs). She finds it helpful to abbreviate information regarding the crash and whiplash-related injuries, but the abbreviations list she uses does not have the medical terms she requires for her practice. Therefore, she includes her own shorthand legend with the standard list she sends out when her charts are requested (see Figure 6-1).

Never eliminate information on a previous health record entry. Cross out mistakes with a single line. Initial and date the error. Do not leave blank spaces where data could be altered (see Amending the Forms section in Chapter 5, Documentation: Intake Forms). In an electronic charting system, the session note is locked when complete, and corrections must be made by noting them in a subsequent note or by attaching a separate document.

Sign your legal name or initials to the end of every chart entry. Never use nicknames—session notes are legal documents. Stay current with legal name changes, which are common with marriage or divorce. Include your health care credentials with your signature. The supervising practitioner signs the chart in addition to student, aide, or apprentice in learning environments or clinic settings.[8]

Write legibly. Insurance carriers can refuse payment if they are unable to ascertain whether the treatment was reasonable and necessary or whether the symptoms warranted the type of treatment.[9] Chart notes are the primary source for verifying this information.

FIGURE 6-1. Addendum to Standard Abbreviations: Motor Vehicle Collision Treatment and Billing Information

Motor Vehicle Collision Treatment and Billing Abbreviations

accel	acceleration
CADS	cervical acceleration deceleration syndrome
CPT	Current Procedural Terminology
G-Force	acceleration force
CMS-1500	Centers for Medicare and Medicaid Services current billing form
HCP	health care provider
ICD	International Classification for Disease
ICE	independent chiropractic examination
IME	independent medical examination
MVC	motor vehicle collision
PCP	primary care provider
PIP	personal injury protection
PR	peer review
pre-IS	pre-injury status
pre-XC	pre-existing conditions
+SB	wearing seat belt
SBD	not wearing seat belt
WAD	whiplash associated disorder

If the notes are illegible, payment can legitimately be denied. Charting is intended to facilitate communication. Make it easy for others to read the information you are trying to share. It is acceptable for your signature to be illegible. Just make sure you have your name, address, and phone number stamped clearly on each page in the patient's file so that others can determine who the practitioner is and how to reach you. EHRs eliminate this issue altogether.

TALES FROM EXPERIENCE

Who to Pay?

An insurance adjuster called needing more information on a patient before she could authorize payment. She couldn't read the patient's name written on the session note, and there was no identifying information about the patient, such as insurance identification number or date of birth. I asked her to fax me the charts because I couldn't place who the patient might be. As the charts came over the fax, I was taken aback. The handwriting was not mine. The initials signing the chart entries were not mine, and the patient was not mine! Not only were the charts missing patient information, but also there was no contact information for the massage therapist. The only legible name on the chart was mine—next to the little copyright symbol (©) in the lower right hand corner of the form. I explained to her that I created the form, but I did not write the chart note. I don't know if the correct massage therapist was ever identified and paid for her services.

Components of the SOAP Format

SOAP notes were created as part of a documentation system called the **problem-oriented medical record (POMR)**, introduced by Dr. Lawrence Weed in the 1960s. Historically, the POMR listed patient problems in the front of the chart, and the practitioner wrote a separate SOAP note to address each problem.[1] Currently, it is acceptable to write one note for each session, addressing all "problems" on the same note. The SOAP format was developed to help structure the practitioner's efforts to solve the patient's health issues. The practitioner records the patient's health concerns and the practitioner's findings, sets goals with the patient, and develops a treatment plan based on the findings and goals. As it was practical and easy to use, the SOAP note became the charting standard in the health care industry. With the onset of EHRs, the standard has shifted to more detailed fields, separates by "pages" that flow in a similar order as SOAP without using those specific headers. Because the information still follows the same order, we will use the format as a general guideline for structuring the information.

Remember, SOAP charting is not required. Laws do not regulate format but may occasionally dictate content. As mentioned in Chapter 4, Why Document?, few states or provinces regulate the format for health record keeping, whereas, all states and provinces regulate how you retain and secure your health records.

SUBJECTIVE

Subjective information provided by the patient includes a health history and current health information. Data collected on the intake forms is considered subjective information and is used to provide comprehensive documentation of the patient's health at the

onset of treatment. Use the subjective sections of the SOAP chart or the initial sections of an EHR as an ongoing record of details about the patient's current health status: current concerns, physical symptoms, emotional complications, changes in functional ability, and impact on the patient's daily routine. On the EHR used as a demo in this book, the first page collects current health information in the form of stress, pain, and activity scales, with a text box asking for an update on health status (see Figure 6-2) and a text box to record patient concerns and symptoms (see Figure 6-3).

On a session note, subjective information can be divided into three parts:

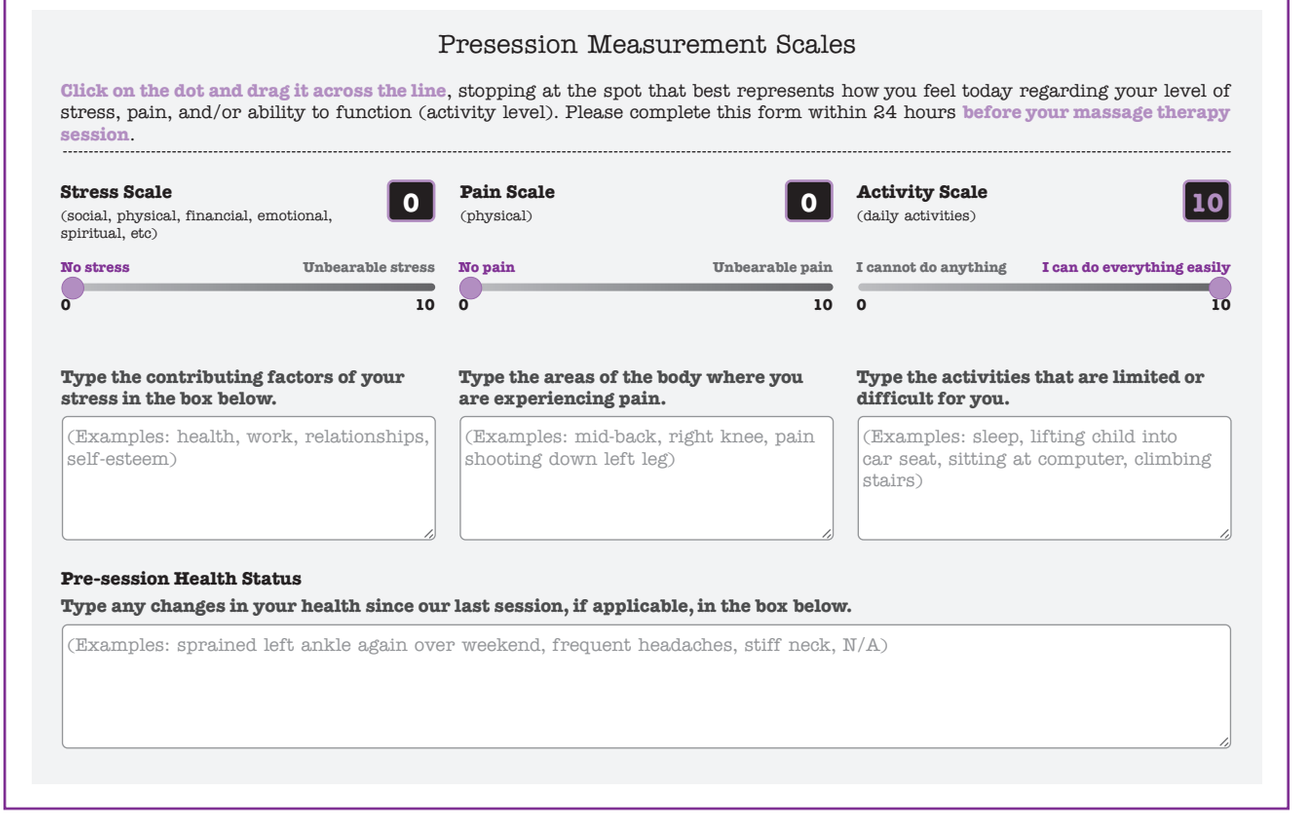
- A prioritized list of health concerns or goals for the session
- Symptoms relating to the current health concerns
- Activities that aggravate or relieve the symptoms

Health Concerns

Place the patient's health concerns at the top of the session note. Remain mindful of the reasons why the patient is seeking care. The patient's health concerns may be defined as injuries, medical conditions, symptoms, or goals for maintaining health or preventing disease. For example, Darnel is seeking care for injuries sustained in a MVC; Tham wants to be able to work without pain or numbness; and Lin is eager to prevent complications of diabetes and learn relaxation skills. Include pertinent information that directly affects the care you provide for the current date of service.

Some of the information may not come directly from the patient. A prescription may provide the diagnosis, or contributing information may come from test results you did not

FIGURE 6-2. Electronic Health Record: Subjective Information Gathering, Page 1



perform. Darnel's X-rays, for example, show degenerative scoliosis; Tham has a diagnosed repetitive stress disorder; and Lin has a family history of heart disease that potentially could complicate her diabetes. This information is critical to the direction of subjective information gathering and the formation of the treatment plan but may or may not have originated with the patient. Typically, this information is found on the health information form, but if diagnoses come trickling in after the fact, write it in the subjective section under health concerns or on the EHR in the presession health status update. References to spinal stenosis or carpel tunnel syndrome will not be misconstrued as operating outside your scope of practice. It is appropriate to list diagnostic terms in this section of the session note because the information comes from the patient or the health care provider (HCP).

Prioritize multiple concerns. For example, Darnel has limited neck ROM, back pain, and headaches. In Chapter 1, Communication and the Therapeutic Relationship, we discussed his strong desire to reduce the back pain so that he could interact with his granddaughter Madi. His headaches are more distressing than his limited neck mobility. Therefore, we would prioritize his health concerns or needs in the following order. Treat injuries and symptoms associated with the MVC including secondary scoliosis recurrence.

1. Reduce low-back pain
2. Reduce headache pain
3. Increase neck mobility

It is imperative to ask patients to prioritize their health concerns, rather than to assume one symptom is more critical than another. For example, Sinan has a list of four concerns he asks to be addressed in his manual: sharp pain in the right hip, low-back stiffness, headache, and swelling in the left thumb. Assuming that the lower body complex is the most pressing concern for Sinan, his manual therapist gets busy working on the lower

FIGURE 6-3. Electronic Health Record: Subjective Information Gathering, Page 2

Notes Treatment +

Treatment

Duration (min)
60

(Subjective Info)

Client Complaints
Heather's scarring from the mastectomies continues to restrict her shoulder mobility L>R, causing her pain 4/10 in the left neck and shoulder. She has difficulty hammering throughout the day, or lifting heavy sheet rock and holding it up while hammering and taping. In the morning, she can dress without pain, but at night has difficulty raising her arms

Assessments/Findings
Record any palpation, movement, posture, or visual findings, if applicable.

Treatment Position/Location
Record the position of the client during the massage (supine, prone, side-lying, seated, etc.) and the body parts you massaged (full body, focus on low back, etc.) and anything you intentionally omitted (no lower extremities due to pitted edema in ankles).

Treatment Techniques
List the techniques applied (NMT, MLD, Relaxation massage, scar massage, etc.)

Additional Notes
Anything regarding client comfort, self-care education/homework, plan for next session, etc.

back, hip, and knee. She does a thorough job but runs out of time before addressing the swollen thumb. By the time Sinan is up and off the table, the lower back, hip, and head feel fantastic. The manual therapist feels confident the session was a success, having accomplished three of Sinan's four concerns. He, however, leaves disappointed. He knows he doesn't have a chance at winning the arm wrestling contest at the pub this weekend with a swollen thumb. Avoid any misunderstandings by asking patients to prioritize their goals for the session. In addition, review your treatment plan with them before you begin the manual.

Symptoms

Obtain a complete list of symptoms from the patient in the initial interview. Much of this information is recorded on the intake forms. Synthesize and condense the information into the initial session note. Inquire about specific areas that have bearing on your treatment applications and are within your scope of practice. Commonly, manual therapists inquire about signs and symptoms in these categories:

- General—fatigue, pain, allergies, fever, posture, and general physical function.
- Lymphatic—swollen nodes, and edema.
- Musculoskeletal—tension, weakness, muscle or joint pain, stiffness, and swelling.
- Peripheral vascular—cramps, varicose veins, cold hands or feet, and color or pallor.
- Neurological—numbness, tingling, local weakness, memory, tremors, fainting, blackouts, seizures, and paralysis.
- Psychosocial—signs of stress or limitations influenced by lifestyle, home situation, a typical day, important experiences, religious beliefs that may pertain to treatment or illness, perceptions of health, attitude, and outlook for future.[4] These may also be support mechanisms that are equally important to note.

Other systems that come into play may not be adequately represented in the intake forms. For further information regarding the systems of the body and examination techniques, consult Bates' *Guide to Physical Examination and History Taking* (12th edition)[4] or Magee's *Orthopaedic Physical Assessment* (6th edition).[6]

Once you have identified symptoms—pain, stiffness, weakness, and the like—ask the patient to describe the symptom's specific location, intensity, duration, frequency, and the setting in which it occurred and recurs. Record that information. For example, headache pain, pounding, left frontal, moderate minus, 2–3 days, monthly, with menses for 10 plus years.

Description

Once the patient has identified the symptoms, ask him or her to describe them further. For example, if the symptom is pain, it may be described as sharp, shooting, dull, or aching. A patient once described her numbness as "cold and wet." Record any information that qualifies the symptom and is helpful in assessing and treating it or in marking progress.

Location

Ask the patient to identify the precise location of the symptom. In addition to locating the symptom, this information can be helpful in identifying the source of the dysfunction and in substantiating progress. As explained in Travell and Simons, the location of the trigger point pain can lead to proper treatment application. For example, if Sinan's headache pain

is located in the forehead over his right eye, the trigger point is likely to be found in the right sternocleidomastoid.[7] Progress can be demonstrated when the area of pain diminishes in size. In the story of Sandee in Chapter 4, Why Document?, her back pain originally covered her entire low-back area. Eventually, the location of her pain was reduced to a small area around her sacrum. Be specific about the location to assist with symptom identification, assessment of the condition, and treatment application.

Intensity

Measure all symptoms by quantifying their expression. Ask patients to rate the intensity of their symptoms on a numerical scale of 0–10, a value scale of mild or light (L), moderate (M), and severe (S), or a descriptive scale of normal (N), good (G), fair (F), and poor (P). The value scale can stand alone as a three-point scale or can be extended into a nine-point scale with the addition of pluses and minuses (L–, L, L+, M–, M, M+, S–, S, S+).

Choose the rating scale that works best for you. Be consistent. If you choose a nine-point value scale, use that scale for all patients at every session.

Frequency and Duration

Note how often the symptom occurs. Use general terms, such as seldom, intermittent, frequent, or constant, or specific descriptions, such as twice a day, three times a week, or hourly, to note the frequency.

Record how long the symptom lasts when it occurs. Use time to denote the duration: seconds, minutes, days, weeks, months, or years.

Onset

The onset describes the setting in which the injury or condition occurred or the external factors affecting the injury and the date of the occurrence. Include the biomechanics of the body positions and movements involved in the injury. For example, Zamora lifted a box of potatoes from the floor to a shelf above her head. She turned to the left to pick up the box and turned to her right to set the box up on the shelf.

In the case of a fall, it is important to note the body parts that came into contact with the type of surface and the order in which this occurred. Zamora, for example, more recently was carrying a 25-pound bag of rice when she slipped on a banana peel at work. She fell backward with her arm outstretched to break her fall, landed on a tile floor on her right hand and right hip, and ended up on her back, with her head hitting the floor and bouncing a few times. The heavy bag of rice landed on top of her. This information helps determine the treatment plan by identifying the points of impact and the angles of entry.

In the case of a repetitive movement injury, the onset includes the repeated action and a description of any other contributing data. For example, Heather hammers repeatedly at shoulder height with right hand, 20 ounce hammer, 8 hours per day, 5 days per week, 5 years at job, carrying heavy nail pouch on left hip.

Include the date of the onset. Be specific to a day, month, and year, rather than a casual reference to "since last Friday" or "when I was sixteen." The latter requires you to make a calculation every time you refer back to the initial session note. Keep it simple.

In situations involving repetitive movement injuries, the date of the onset may be difficult to determine. As in the aforementioned scenario, help Heather determine the approximate year the symptoms began occurring. To Heather, it may feel like the pain has been going on forever, but if you prod her memory a bit by suggesting 10 years or 20 years, she's likely to narrow the timeframe down a bit. Record a month or a time of year as well as the year of onset, if possible. Noting "Summer of '42" or "January '03" is more helpful than a simple "for many years."

Having a clear record of the mechanisms of injury will help justify treating a broader area. For example, with Zamora's lift and twist injury, the diagnosis may be a low-back sprain–strain. Treatment to her neck and shoulders may seem luxurious and unnecessary to a referring HCP or an insurance representative unless you can clearly explain the biomechanical links and compensating symptoms involved.

Activities of Daily Living—Aggravating and Relieving

Emphasize function, such as how well the patient is able to perform daily activities, when charting subjective information. Record the patient's current and prior level of function, how the symptoms affect his ability to function, and how his ability to function affects his life at home and work. Prior function helps you determine when the patient reaches preinjury status.

The documentation process—inquiry, discussion, and charting—increases patients' awareness of their role in exacerbating or reducing the symptoms. Record events of everyday life that aggravate or relieve symptoms to document significant injury, note progress, and educate patients to use activities that relieve rather than aggravate their symptoms.

The information regarding patients' activities of daily living (ADLs) will assist you in proving functional progress and providing effective self-care education. Functional limitations that have the most effect on their quality of life will be used to determine LTGs and STGs. Use relieving activities when planning their homework and self-care regime. Goals and outcomes are documented in the assessment section; homework is described in the plan section.

Activities That Aggravate Symptoms

When documenting activities that aggravate the patient's symptoms, be specific about home and work responsibilities, including hobbies and play activities. Generally speaking, activities are pertinent to the individual patient and involve basic functions: sitting, standing, walking, lifting, sleeping, and the like. Use the pain questionnaires to identify the basic functions with which patients experience difficulty. In this section of the session note, however, explain how each function personally relates to the individual's daily activities. Include the relevance of the specific activity to the patient's life, how long the patient can perform the activity before the symptoms begin or worsen, and compare with the patient's previous ability. For example, pain increases from mild to moderate with sitting or standing more than 30 minutes. The patient typically sits at the computer for 7–8 hours a day for work, stands in kitchen 1–2 hours per day doing household chores, and reads for recreation. The patient is unable to drive comfortably for more than 10 minutes, yet has a 35-mile commute to work, picks the kids up from day care, and has a road trip through the Canyon Lands scheduled next week with the family.

Include activities the patient can no longer perform because of the symptoms. For example, unable to lift objects heavier than 25 pounds—job requires lifting objects up to 60 pounds, exercise routine included weight lifting, and small children at home require lifting for care. Address endurance by describing an activity and stating the amount tolerated before signs of fatigue are exhibited. For example, must stop reading after 20 minutes and housework after 10 minutes because of pain and fatigue.

When daily activities change noticeably but symptoms remain constant, a look at aggravating activities may reveal progress that might otherwise go undetected. Often, when patients are recovering from injuries that have limited them, the better they feel, the more they attempt to do. They are eager to return to work, get out of the house, and feel useful again. The weeds in the garden are nagging them, the stack of laundry is piling up, and the

kids want to get the flat tire fixed on the bike. When the activity level increases, there may be little to no improvement in symptoms—symptoms may even worsen. Rather than assuming there is no progress, document the changes in activities. This will explain the lack of progress with the symptoms and show improvement in the patient's health based on activity level.

TALES FROM EXPERIENCE

Pain Threshold Affects Patient Perceptions of Progress

I was a bit lazy charting sessions with a fellow massage therapist who had been in a car collision. Angela's knee was injured in the crash and required surgery. At first, I was diligently recording her functional limitations and helping her set functional goals. For example, she was ambitious about attending the opening of a basket exhibition, and we worked together to set reasonable goals regarding her ability to walk around the gallery. With frequent stops to sit and rest, she was able to see each basket in the exhibit!

Six weeks later, Angela seemed very down about her condition. She complained that she felt little progress and was experiencing pain every day while walking and standing. Realizing that weeks had gone by since I questioned her regarding her daily activities, I asked her how much walking she was doing. "I'm walking to and from work every day, and it always hurts!" I knew she lived a mile from her office atop a hill. Angela had returned to walking the two miles round trip just 4 weeks after her stop-and-go limp around a gallery. I was impressed! As her therapist, I was able to maintain perspective of Angela's progress, but Angela couldn't see beyond the fact that today she was in pain. Somehow, I needed to help Angela remain cognizant of her progress.

I told Angela my painful story of being introduced to 100 MDs at the CAM symposium and what I had learned from the chronic low-back pain study[8] (refer to the Tales from Experience in Chapter 1, Communication and the Therapeutic Relationship). After discussing how one's threshold of pain can affect one's perception of progress, she agreed that we had not focused adequately on her functional successes; namely, the dramatic shift in her ability to walk. We made a commitment to set goals every month and regularly evaluate her functional progress until all her goals for health were met.

Activities That Relieve Symptoms

List activities that alleviate symptoms. Include how they modify necessary activities and what additional self-care, exercises, or remedies they now incorporate that relieve the symptoms. Changing positions, taking frequent breaks, stretching exercises, self-massage, topical analgesics, and hot or cold packs are also considered activities that alleviate symptoms.

Investigate closely the steps the patient has taken to care for self. Uncover as many ways as possible that the patient participates in her health care. Document specific activities that you want to reinforce or that have been particularly effective. For example, Catherine Ann applies ice to lower back as needed for pain, sits on a tennis ball to relieve trigger point pain, and squeezes tennis ball throughout day to exercise hands. You may choose not to record all the information uncovered but use it to compliment the patient, build her self-esteem, and encourage her to continue to participate in her health care.

OBJECTIVE

These sections of the session note store information from the practitioner's perspective such as the following:

- Measurable data—movement tests, palpatory findings, visual observations
- Treatment applications—techniques, location, duration
- Patient's response to the massage

State information clearly and concisely. Stick to details within your scope of practice. Do not chart treatment techniques for which you cannot explain the physiological effects clearly and consistently. Avoid data that cannot be measured or reproduced.

Measurable Findings

Massage therapists primarily gather the following objective, measurable data: visual observations, such as posture and breath, and palpatory findings, such as spasms and trigger.

- Document a full range of data.
- Measure every finding.
- Measure before and after treatment application.
- Perform the postassessment in the same way as the preassessment.
- Use consistent terminology and symbols.

The data you record should represent the full scope of your practice. Do not limit yourself by narrowly focusing on one aspect of your expertise. This can cause problems when others in your profession exercise the full extent of the professional scope.

TALES FROM EXPERIENCE

The Laundry List of Hypertonicities

I attended a meeting with reviewers and medical directors from a few insurance companies. I was there to defend the scope of practice of massage therapists as a result of a narrowing interpretation of our assessment and treatment abilities. The medical director of one of the health plans claimed she was getting hypertonicities from reading about all the hypertonicities on therapists' session notes. She wanted to know why the providers in her network insisted on listing every tight muscle in the body and nothing else and whether indeed the therapists were capable of noting inflammation, spasms, trigger points, joint dysfunction, and such. Tight muscles alone do not provide a convincing argument for medical necessity. Balance your objective charting by noting a variety of findings.

Measure all information. Quantify and qualify data based on deviations from normal. Normal is determined by the following:

- Comparing bilaterally when possible
- Defining normal for a general population of similar constitution
- Asking the patient to define normal for himself or herself

Quantify data by rating the intensity of its expression. For example, trigger point moderately painful with light digital pressure at the trigger point site and mildly painful at the referral site, or cervical flexion passive ROM was limited 4/10 with 2/10 pain at end range.

Qualify data by describing its expression. For example, right shoulder active abduction moderate segmented movement with mild compensatory shoulder elevation at end range or moderate plus sharp shooting pain with movement from prone to supine position while turning on treatment table.

Assess the condition before and after treatment. It is difficult to document progress or determine the effectiveness of a treatment modality without being able to do a before-and-after comparison. For example, moderate trigger point site pain changed to mild pain, mild referred pain changed to no pain, or moderate segmented movement in right shoulder active abduction changed to smooth movement without compensatory shoulder elevation. The Hands Heal EHR system collects pain, stress, and activity data via pre- and postmeasurement scales, and the system graphs it automatically to show progress before and after every session and over time.

Perform assessment tests identically for pretreatment and posttreatment. Data must be comparable. For example, postural analysis in a standing position (weight bearing) provides different information from postural analysis in a supine or seated position (non-weight-bearing). Therefore, the patient should be in the same position for both tests. Moreover, reproduce the test in the original environment. For example, if the patient was sitting in a chair for the pretreatment ROM assessment, he or she should be sitting in the same chair, not on the treatment table, for the posttreatment assessment.

Be consistent from session to session. It is difficult to compare data over time when the ROM testing was done standing initially, seated last session, and supine this session. Moreover, take into consideration the timing of the tests. If the initial test was done on a Friday afternoon after a long week at work and the test was reassessed on a Monday morning after a relaxing weekend, the data will not be comparable.

Pick qualifying and quantifying terms and use them consistently. Smooth, segmented, and spastic may describe the quality of the range of motion. Sharp and dull can be used to qualify pain. Numerical scales (0–10) or value scales (L, M, S) can quantify data. Select terms that adequately represent your assessment test results. Create abbreviations for the terms when necessary and add them to your legend. Most importantly, use the same terms consistently from session to session and patient to patient.

Visual Observations

Visual findings stem from observing movement patterns such as posture, muscle atrophy, skin abnormalities, swelling, and signs of trauma (such as bruises, abrasions, and scars). Much of the visual data can be recorded on the session note by drawing symbols on the human figures. For example, posture is easily noted on the figures by drawing skewed lines to depict elevations and arrows in the direction of rotations. Use standard symbols to represent visual findings, or you may add your own to the key. Functional movement patterns, such as gait or respiration, and comments about general appearance are more easily noted in the space provided for written information (see Figure 6-4).

Follow these guidelines for documenting posture and movement patterns:

- Note the position of the patient—seated, standing, prone, supine
- Record the angle of the observation—anterior, lateral, posterior
- Describe the activity being observed—breathing, walking, lifting, standing
- Follow the guidelines for gathering and charting objective findings (listed previously)

FIGURE 6-4. Objective Section: Visual and Palpable Observations

HANDS HEAL

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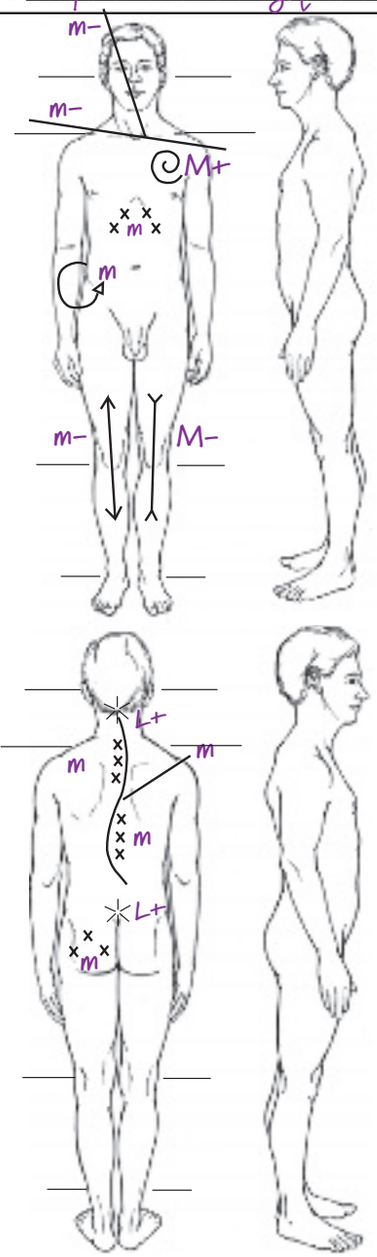
SOAP CHART-M

Patient Name Darnel G. Washington Date 2-6-17

Date of Injury 1-6-17 ID#/DOB 123-45-6789 Meds hydrocodone 500mg q4h



O Findings: Visual/Palpable/Test Results

v: Primary weight bearing rising and standing–
right leg and foot–moderate
sits on right pelvis–moderate
bends from mid–thoracic–moderate
breath shallow and rapid–moderate
segmental rib movement on left with deep inhalation–
moderate

P: right frontal torsion–moderate
bilateral sphenoid compression–moderate
adhesion tentorium–mild
cranial rhythm weak, right–moderate
left–mild

Provider Signature JO, LMP, GCFP Date 2-6-17

Legend: ⊜ TP • TeP ○ Ⓟ ✳ Infl ≡ HT ≈ SP
× Adh ≋ Numb ⟲ rot ⟋ elev ⟝ Short ⟷ Long

For example, patient supine, anterior–lateral view, deep inhalation, mild plus mobility restriction in the upper right quadrant.

Posture can be quantified by rating the amount of deviation from normal. Simply mark a number or letter denoting the intensity of the deviation near the line or arrow as it is drawn on the figures.

Chart irregularities: forward head posture, leg length variations, spinal curvatures, and the like. Note elevations, rotations, inversions, and eversions. Common sites for observing posture are at the ears, shoulders, superior and inferior angles of the scapulae, anterior and posterior superior iliac spine, knees, and the medial and lateral malleoli.

Breath can be measured by qualifying the pattern and rate of breath, describing sounds associated with breathing and quantifying the mobility of the ribs with inhalation. Note irregularities such as a rattling noise or shallow, rapid, weak, uneven, or inconsistent patterns in breathing. Observe the rise and fall of the ribs and chart the restrictions.

Functional movement patterns can be qualified and quantified by noting the amount of movement, how well the movement is performed, and how long the patient can sustain the movement before experiencing fatigue. Note sensations caused by movement and rate.

Palpation Findings

Palpation is an objective test used to locate and assess inconsistencies in various rhythms, pulses, and systems of the body such as soft tissue, joints, viscera, and lymph. Massage therapists tend to be highly trained and adept at sensing subtle discrepancies and changes under their fingers. As a result, detailed palpatory information is a valuable resource for all caregivers involved in the patient's health care team, and the information can be shared through session notes and progress reports.

Document palpation findings by noting and describing abnormalities and conditions. Terminology varies among professions and specialties. Compile a comprehensive list of evaluative terms for your practice and use the terms consistently. Your list may include the following:

- Muscle tone—including tension, hypertonic, hypotonic, spastic, rigid, splinting, contracture, spasm, lines of tension, holding patterns
- Pain—including trigger points, tender points, meridian points, Jones points, absence of sensation, spasm–pain–spasm cycle. (Note: Pain is usually considered subjective information. Pain becomes objective when it is elicited by the practitioner through touch, testing, and the like.)
- Scar tissue—adhesions, fibrosis, fibrotic tissue, granulation tissue
- Inflammation—including swelling, edema, active hyperemia, ischemia, congestion, stagnation, heat, pitted edema

Avoid diagnostic terms, such as grade 2 sprain or strain and lymphedema, to describe findings if you do not have diagnostic scope or if the referring HCP or the patient did not provide you with diagnostic information.

Measure the palpation data by rating the intensity of the finding, such as with severe spasm, or quantifying the size, such as with right ankle edema 20 cm in circumference.

Much of the data collected through palpation is documented easily on human figures using symbols found in the legend. Write the quantifying or qualifying terms next to the figure. Whenever necessary, tie the letter or number to the symbol with a connecting line. Anything too complicated or cumbersome to draw on the figures can be written out in the space provided (refer to Figure 6-4). The figures are intended to increase the speed and ease of documentation and to aid in fast recall. This intent is defeated if the figures are

overburdened with symbols. When the data are abundant, draw the primary information on the figures and list the secondary data in the space provided under objective.

Follow these guidelines when documenting palpation findings:

- Identify the specific location.
- Rate or describe the type of touch that triggers the finding (for example, light, medium, or deep).
- Include any referred sensation, if applicable.
- Identify connections or relationships, if any.
- Follow the guidelines for gathering and charting objective findings (listed earlier in this chapter).

For example, left biceps insertion moderate pain with light digital pressure, mild plus referred pain into left elbow.

Range of Motion Testing

The most common standardized testing for massage therapists is ROM testing (see online, Appendix B for blank forms). It is used in many professions and is familiar to lay people as a means of assessing health. A popular television commercial shows a person bending over and touching his toes, at first with limitation and pain, then—after taking the product—with greater range and ease. The message: Greater movement with less discomfort equals better health. As a result, many patients expect ROM testing from any practitioner assessing and treating joint pain.

ROM testing is a valuable assessment tool for determining the stage of inflammation, the level of severity of sprains and strains, joint trauma, and muscle weakness. Gather and record ROM test results to substantiate dysfunction, validate progress, and identify conditions. Assessing ROM before treatment substantiates the limitations for the patient. Retesting ROM after intervention demonstrates the effectiveness of the treatment plan and proves progress resulting from the session. Periodic testing at pretreatment and post-treatment times shows continued progress and gives the patient, the referring caregivers, and the insurance reviewers evidence that the treatment is working.

Document the test.

- Identify the position of the patient—standing, seated, prone, supine, side-lying
- Identify the type of test—active, active assisted, passive, resistive
- Name the joint—including right shoulder, left hip, cervical spine
- Name the action—including flexion, extension, left rotation, right lateral flexion
- Chart the results of the test (see Figure 6-5)
- Rate the amount of movement as a deviation from normal—hypermobile, hypomobile, within normal limits (for example, moderate decrease in seated active cervical flexion …)
- Rate the presence of pain with movement or stretch (for example, … with moderate pain)
- Rate the quality of the movement—including smooth, segmented, spastic, rigid (for example, … with mild segmented movement)

ROM test results are commonly expressed in degrees or percentages of normal. If you are not using measuring devices such as goniometers, use the numerical scale of 0–10 or the value scale of mild, moderate, and severe to rate ROM test results. You will be able to show deviations from normal with enough detail to note progress as changes develop. (For information on how to perform ROM tests or use goniometric measurements, see Kendall et al.[9] or Norkin and White.[10])

Treatment

Document the length of the session, the massage techniques and modalities used, and the location of the treatments that were applied. Record the treatment in two ways. First, provide a big picture of the session—the length of the session, techniques, and general body parts treated. For example, 1 hour full-body Swedish massage; 30-minute foot reflexology; or 90-minute Hellerwork—inspiration. Second, fill in the details—particular techniques used to treat specific findings. For example, muscle energy technique with cervical flexion, direct pressure on scalene trigger point, or myofascial release on diaphragm. You do not need to write down everything you do, just give the highlights. Chart enough information to recall the important events of the session at a later date.

Patient's Response to Treatment

Every subjective and objective finding should be reassessed during the session. This may happen as you go—immediately after a specific technique is applied to address a particular symptom—or at the end of the session.

Quantify and qualify the changes. Include positive and negative responses to treatment. Record the updated information on the chart above or alongside the original entry. Use the delta symbol (Δ) to distinguish the pretreatment data from the posttreatment entry (see Figure 6-6).

This is an efficient way to document the patient's response and avoid rewriting in several places on the chart.

Note symptoms and measurable data that did not change. This may help you determine areas of focus for the next session. Identify whether the treatment was ineffective or whether time did not permit addressing the issue. In either case, you will want to address

FIGURE 6-5. Range of Motion (ROM) Chart

HANDS HEAL

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RANGE OF MOTION

Patient Name Darnel G. Washington Date 2-6-17

Date of Injury 1-6-17 ID#/DOB 123-45-6789

PRETEST 1 Initials JO Date 2-6-17

Position of patient: prone, sidelying, sitting, (standing), supine, other: _____

Type of test: (active), active assisted, passive, resistive, other: _____

Joint: C-spine, T-spine, (L-spine), hip, knee, ankle, shoulder, elbow, wrist, other: _____

Action	Quantify ↓ or ↑		Rate Pain		Rate Quality	
	Ⓡ	Ⓛ	Ⓡ	Ⓛ	Ⓡ	Ⓛ
flex	M⁻ —	↓	L —		L —	seg
ext	M⁺ —	↓	M —		M —	seg
SB	L↓	M↓	L	M	N	M seg

POSTTEST 1 Initials JO Date 2-6-17

Position of patient: prone, sidelying, sitting, (standing), supine, other: _____

Type of test: (active), active assisted, passive, resistive, other: _____

Joint: C-spine, T-spine, (L-spine), hip, knee, ankle, shoulder, elbow, wrist, other: _____

Action	Quantify ↓ or ↑		Rate Pain		Rate Quality	
	Ⓡ	Ⓛ	Ⓡ	Ⓛ	Ⓡ	Ⓛ
flex	L —	↓	~~0~~ —		N —	
ext	M —	↓	M⁻ —		L —	seg
SB	~~Δ~~	~~Δ~~	~~Δ~~	L	N	L seg

FIGURE 6-6. Objective: Response to Treatment

HANDS HEAL

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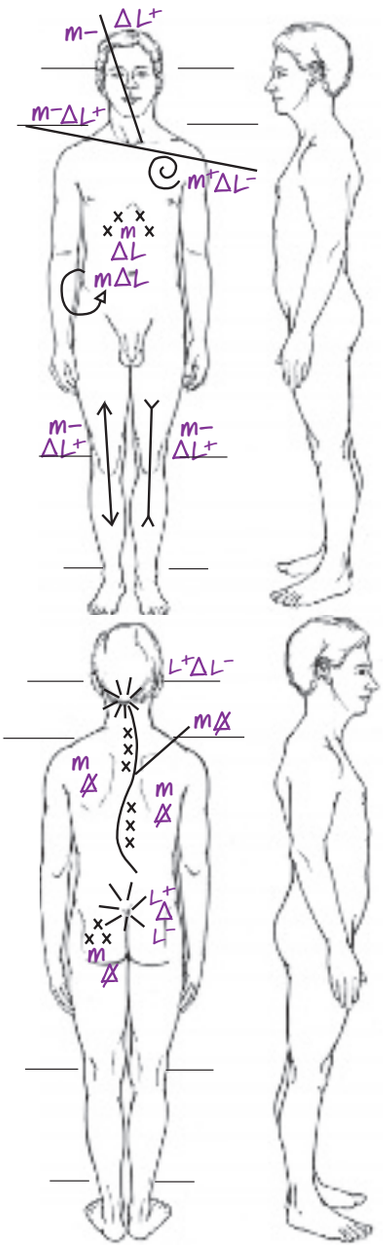
SOAP CHART-M

Patient Name Darnel G. Washington Date 2-6-17

Date of Injury 1-6-17 ID#/DOB 123-45-6789 Meds hydrocodone 500mg q4h

S Symptoms: Location/Intensity/Frequency/Duration/Onset

Neck, mid, low back pain moderate
constant since car accident Δ L
headache Pain moderate intermittent
daily since car accident Δ Ⓟ



O Findings: Visual/Palpable/Test Results

V: Primary weight bearing rising and standing–
right leg and foot–moderate X
sits on right pelvis–moderate X
bends from mid-thoracic–moderate Δ L
breath shallow and rapid–moderate Δ L
segmental rib movement on left with deep inhalation–
moderate Δ smooth

P: right frontal torsion–moderate Δ L
bilateral sphenoid compression–moderate Δ M–
adhesion tentorium–mild X
cranial rhythm weak, right–moderate Δ L
left–mild Δ Normal

Provider Signature JO, LMP, GCFP Date 2-6-17

Legend: ⊜ TP • TeP ○ Ⓟ ✳ Infl = HT ≈ SP
X Adh ≋ Numb ↻ rot / elev ⟝ Short ⟷ Long

the problem in the treatment plan; make the issue a priority for the next session; or select another technique to use. "No change" is easily abbreviated with a line drawn through the delta symbol (Δ/).

ASSESSMENT

Traditionally, the assessment sections of the session note record the practitioner's interpretation of the subjective and objective findings. Conclusions are drawn, the condition is named (diagnosis), and the prognosis—probable course of the disease—is determined and recorded on the session note. However, practitioners without diagnostic scope are not permitted to assess the patient's condition in these terms.

In functional outcomes reporting, assessment is the place to summarize the patient's functional ability—to set goals that, when accomplished, demonstrate functional progress. Every practitioner using the functional approach to charting will record functional goals and outcomes in the assessment section. If the patient does not have any functional limitations but does have a medical condition that warrants documenting, leave this section of the SOAP chart blank or simply do not include it in the assessment sections of the session note on the EHR. Before you fall back on this option, however, question the patient regarding his or her sleep patterns. Most people living with pain have disruptions in their sleep, even when they are still able to perform all other ADLs without modification. If they are waking during the night because of pain or are waking in the morning feeling fatigued, set measurable goals regarding sleep and note measurable progress as they achieve their goals. Record the following in the assessment sections:

- Long-term and short-term functional goals based on activities of daily living
- Functional outcomes

FROM THE LITERATURE
Follow the Patient's Lead

"You should never have expectations for other people … setting goals for others can be aggressive—really wanting a success story for ourselves. When we do this to others, we are asking them to live up to our ideals. Instead, just be kind." This quote from Trungpa Rinpoche reminds us to follow the patient's lead in setting goals. Remember that the patient is in charge in the therapeutic relationship. SOAP notes were designed to help formulate a high-quality treatment plan and promote the practitioner's problem-solving skills. This same format can be equally effective in promoting the patient's problem-solving skills by adding the functional outcomes approach to our information gathering and charting. Focus on the therapeutic relationship and prioritize the patient's goals above our own in every step of charting treatment sessions.

The functional outcomes style of documentation is increasingly popular and benefits the patient, the practitioner, and all who read the chart because it directly addresses the basic needs of the patient, monitors effective treatment, and makes the results easily understood—not just to the experts.

Reprinted by permission from Chödrön. ***Start Where You Are: A Guide to Compassionate Living***. Boston: Shambhala; 1994.

Functional Outcomes Begin as Goals

Functional outcomes are written in the form of functional goals, which are set by the patient with practitioner guidance. Goals are determined through the activities with which the patient is having difficulty and with which the patient is motivated to resume. As they are accomplished, the goals are identified as functional outcomes.

Develop goals that address the needs of the patient and lead to an effective treatment plan—one that will resolve the patient's concerns. With the patient, follow these steps:

- Summarize and prioritize verbally the patient's functional limitations, referring to what is already written in the subjective sections of the session note.
- Relate these functional limitations to all meaningful and pertinent ADLs and review these with the patient.
- Select one activity that is adversely affected by the patient's condition—one to which the patient is most motivated to return.
- The more specific the activity, the easier to note progress.

Setting SMART Goals

To ensure that the goals will lead to productive treatment plans and produce functional outcomes that serve the patient's needs, follow the **SMART goals** criteria.[11] The acronym SMART stands for the following:

Specific—to a daily activity
Measurable—quantified and qualified to note incremental progress
Attainable—able to be accomplished given the patient's condition
Relevant—critical to the patient's daily life
Time-bound—defined to be successful in a specific amount of time

With the patient, build functional goals that meet the SMART criteria.

SMART—Specific and Relevant Activity

Select activities that are specific and functional. This can include vacuuming, mowing the lawn, washing hair, lifting boxes onto a conveyor belt, loading and unloading furniture to a truck, rowing a boat, and the like. The more specific the activity, the better the treatment. "Work," "exercise," "child care," and "housework" are not specific enough to base a functional goal on. If house cleaning is the work, explore the activity that increases the symptoms—is it standing at the sink, pushing a vacuum cleaner, pulling sheets off a bed, lifting laundry, or scrubbing floors? If computer programming is the work, is it sitting still, staring at the screen, or moving the mouse? If the exercise is playing tennis, is it the forehand stroke, backhand, serve, or lateral moves? What part of child care is problematic—lifting the child, leaning over to play with him or her, or picking up the toys?

Reducing pain is a common goal of the patient but is not functional—based on an activity. Pain is a qualifier, measuring the success of a goal. If a patient states "pain free" as his or her goal, guide him or her to a specific activity by exploring activities that cause the pain.

Select the activity that is most relevant to the patient's life. Address work, home, family, exercise, and play activities. The goal should be based on an activity that is critical to the patient's ability to earn a living or care for self, family, or household. If the injury occurred on the job and industrial insurance is paying for the treatment, select a work-related activity.

SMART—Measurable and Time-Bound

Once the specific and relevant activity is selected, specify how the success of the goal will be gauged.

1. Quantify the outcome by measuring the activity—number of units, amount of weight, repetitions, duration, or frequency.
2. Qualify the outcome by projecting how the patient will feel on completion—amount of pain, fatigue, or functional limitations.
3. Schedule a time limit for completion—commonly 30–60 days for LTG or about 1–2 weeks for STG. Be specific, for example, 45 days, not 30–60 days.

For example, lift 25-pound boxes from a three-foot-high, moving conveyor belt and stack them onto hand trucks for 30 minutes keeping pace with the conveyor with no more than mild pain within 6 weeks.

1. Quantify the outcome—lift 25-pound boxes from a three-foot-high, moving conveyor belt and stack them onto hand trucks for 30 minutes keeping pace with the conveyor
2. Qualify the outcome—with no more than mild pain
3. Time-bound—within 6 weeks

Climb up and down four standard steps at a moderate pace three times a day with moderate pain and mild fatigue within 1 week.

1. Quantify the outcome—climb up and down four standard steps at a moderate pace three times a day
2. Qualify the outcome—with moderate pain and mild fatigue
3. Time-bound—within 1 week

Sleep restfully for 3 hours without waking once each night with mild fatigue on waking within 2 weeks.

1. Quantify the outcome—Sleep restfully for 3 hours without waking once each night
2. Qualify the outcome—with mild fatigue on waking
3. Time-bound—within 2 weeks

Two standard time frames can be used: long-term and short-term. LTGs are developed first. Identify the desired end result of the treatment. If it is not possible to reach the goal in 30–60 days, write one or two intermediary LTGs, each one attainable within 30–60 days.

STGs are established to support the LTG and are often written as incremental stages of the LTG. Think of them as baby steps toward the end result. If the end result is to lift boxes that weigh up to 50 pounds from the floor to a truck up to 100 times a day for 5 days a week, write STGs that are fractions of the original goal. For example,

STG #1: Lift 10 pounds from a three-foot-high shelf 10 times a day within 12 days
STG #2: Lift 20 pounds from a two-foot-high shelf 10 times, two times a day within 20 days
STG #3: Lift 30 pounds from a one-foot-high shelf 20 times, three times a day within 12 days

Write STGs that provide encouragement and motivation for the patient, even if the STG does not appear to be directly related to the original goal. For example,

LTG—pain free and fully functional while swimming the breast stroke for 1,500 m within 30 days. If the breast stroke is painful because of a neck injury but the patient is eager to experience success in the water, set a goal that provides a feeling of success in the water. STG—one-week goal of 30 minutes of water aerobics with moderate pain. The aerobic exercises may not require the patient to extend his or her neck—the function that causes pain—and being in the water may be very comforting for the patient. The result is an immediate feeling of accomplishment that may not be realized with long-term goals (LTGs).

The time limit for LTGs is often dictated by the prescription length. One or two STGs should be written for each LTG. Determine the measurements for the time frames by assessing the possibilities for each patient, given his or her condition and constitution.

REFINE YOUR SKILLS

Practice Setting Functional Goals

In class or a study group, divide into small groups of three to four.

Using one person in the group who has a soft tissue complaint (if all are healthy, make up a scenario), identify a functional limitation. It could pertain to sleep, a daily activity, or his or her ability to provide massage therapy. Describe it as fully as possible. Then, as a group, identify two STGs and one LTG. If there are several groups doing the exercise, have each write the three goals on the board. Give each other permission to put on your critical thinking caps and check each set of goals against the SMART criteria. Is the function stated as a specific ADL? Has the goal been quantified and qualified? Is it set in time? Does it seem attainable given the patient's previous ability and current condition? Write corrections as the feedback is provided.

SMART—Attainable

Be reasonable when writing goals. A goal that is too vast—pain free and fully functional while swimming the breast stroke for 1,500 m within 30 days—can be frustrating to reach when the patient is currently unable to swim owing to pain and limited ROM. If we are to eliminate the patient's feelings of powerlessness and inspire him or her to work hard to achieve his or her goals, we must develop goals that are not only meaningful but continually are within the patient's reach. Evaluate the severity of the injury, the patient's constitution, and functional status and then determine whether the goal as stated is attainable for the patient in the allotted time.

It is helpful to predetermine how the patient's body will respond to treatment. Don't worry if you misjudge this; you can adjust the goal at the following session by renegotiating the time limit or the outcome measurements. Instead of swimming 1,500 m with no pain, adjust the outcome as follows:

The patient will be able to swim 500 m with moderate pain within 30 days.

PLAN

The plan sections chart the future treatment protocol and record self-care exercises. Set treatment goals and list probable treatment options for obtaining the goals. Outline the

frequency of the sessions and duration of each and settle on an approximate reevaluation date. Chart specific instructions for homework suggestions. Document your referrals and recommendations for outside interventions and tests.

Treatment Plan

The initial note projects the plans for the first series of treatments. First, given the information shared in the extensive initial interview and full-body assessment, determine and prioritize your goals for the series, an example of which is as follows:

1. Reduce inflammation in the neck
2. Reduce pain in the neck and shoulders
3. Increase ROM of the neck

Next, the practitioner and the patient select massage techniques and modalities to use that will accomplish your goals and the patient's functional goals. Base your decision about treatment techniques on what has worked for the patient in the past and what has worked for others who have had similar conditions and constitution. List the techniques projected and the general locations for applying the massage, as mentioned in the following example.

1. Lymphatic drainage and ice packs on the neck to reduce the inflammation
2. Swedish massage and trigger point therapy on the neck and shoulders to reduce pain
3. Muscle energy technique to the levator scapulae and sternocleidomastoid to increase ROM

Record the frequency of the subsequent sessions—3 times a week, weekly, or monthly; duration of sessions—30 minutes, 1 hour, or 90 minutes; and the reevaluation date. The plan should cover the length of the prescription or the time allotted for the LTG. If you are treating the patient twice a week, a 30-day reevaluation date is appropriate. If the treatment frequency is once a week, 45 days between reevaluations may feel adequate. For example, the note may read: 45-minute sessions; twice a week for 3 weeks, reevaluate during the week of 06/15/18.

Update the plan every 30 days or more, depending on the treatment frequency. Modify the plan more frequently whenever the patient's condition changes or the plan is no longer appropriate based on the patient's response to the previous treatments. Let the individual needs as they arise. Remain mindful of the goals at the same time.

Self-Care

Record **self-care** exercises and homework assignments that support the goals. Self-care is a broad term that includes modifying activities to decrease pain and effort and increase safety, stretching and strengthening exercises, and home remedies such as ice packs, Epsom salt baths, poultices, ointments, and self-massage techniques. Compliment the patient on everything he or she currently does to improve his or her condition and reinforce his or her efforts by charting the self-care exercises that are most productive.

Be specific and provide detailed instructions when assigning homework. Support the patient's self-care routine by recording the homework assignment and the specific instructions or attaching a copy of the instruction sheet to the chart. This is difficult

to do if we cannot remember the assignment. For example, stand up and stretch for 2 minutes for every hour of work at the computer. Hold all stretches for 30 seconds. Stretches include

1. bending over slowly and touching toes; return to standing
2. bending over to each side; return to standing
3. pulling arms behind back using filing cabinet; before sitting down, walk to the water fountain and drink

Keep homework simple. Make sure it fits into the patient's lifestyle. If the patient is very busy, homework should not be too time-consuming. New exercises should not be too complex, so assign activities that the patient will find familiar and comfortable. Ideally, homework should be the patient's idea or a modification of something the patient suggests.

Remember, do not provide homework to people who are not ready for it. Some patients do not yet believe that change is possible. Assign awareness exercises for patients who are unaware of their role in the healing process and don't seem to recognize change when it occurs. Invite them to notice the way they feel when they are performing an activity that exacerbates their condition. For example, for every hour spent at the computer, stop and take a break. Notice how your neck, back, arms, and hands feel. Notice whether anything you do makes that feeling better or worse.

Initial Notes, Subsequent Notes, Progress Notes, and Discharge Notes

Four types of notes are recorded on the two SOAP formats: the extended version and the short version. The extended version is a full-page SOAP chart on paper with multiple prompting categories. The short version is a half-page form on paper with only the SOAP sections noted (see online, Appendix B for blank forms). Because electronic session notes are inherently flexible, incorporate the following information into the sections provided in the system.

- Initial notes (extended version)
- Subsequent notes (short version)
- Progress notes (extended version)
- Discharge notes (extended version)

Initial notes are comprehensive and include extensive information regarding the patient's health and current situation. Much of the information recorded on an initial session note does not need to be repeated on subsequent notes. Use the extended version of the SOAP form (see Figure 6-7).

- List and prioritize all of the patient's health concerns
- Evaluate the full body, including the way the patient is responding to his or her current health situation from head to toe
- Include all symptoms that relate to the patient's health concerns, the impact of the condition on the patient's life, and all objective findings, including compensational holding patterns and concomitant dysfunctions

FIGURE 6-7. Initial SOAP Chart: Paper Version

HANDS HEAL

John Olson, LMP, GCFP
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PHONE 612 555 9889 • EMAIL olson@email.com

SOAP CHART-M

Patient Name Darnel G. Washington Date 2-6-17

Date of Injury 1-6-17 ID#/DOB 123-45-6789 Meds hydrocodone 500mg q4h

S Focus for Today ↓ Pain in head, neck, back

Symptoms: Location/Intensity/Frequency/Duration/Onset

Neck, midback, low back pain moderate
constant since car accident Δ L
headache Pain moderate intermittent
daily since car accident Δ Ⓟ

Activities of Daily Living: Aggravating/Relieving

A: 1. lifting granddaughter—necessary for care: in & out of car seat, high chair, bed etc.— Ⓟ M+ pain every time
2. gardening—vegetable and flower garden, bonding time with wife—unable to garden over 5 min.
3. unable to sit & play bridge over 30 min.
R: rest, heat

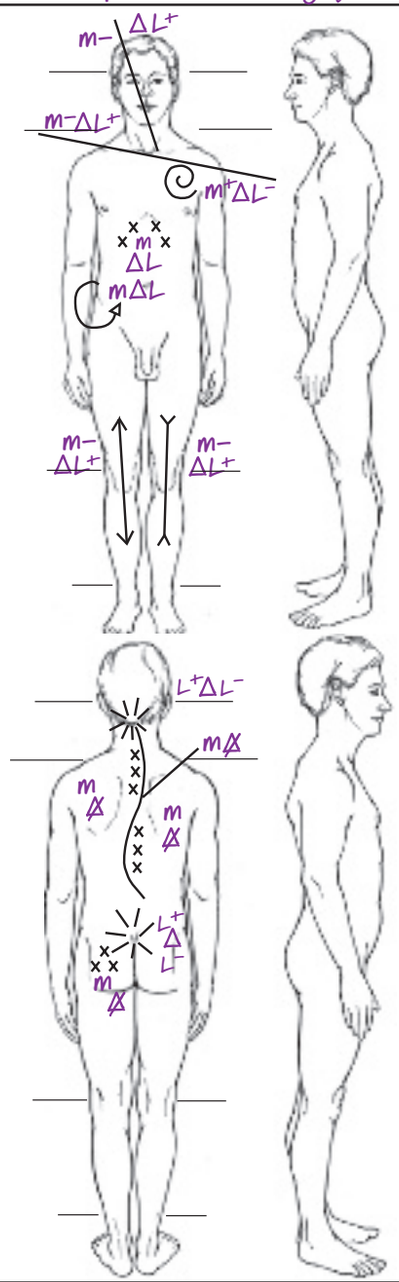
O Findings: Visual/Palpable/Test Results

V: Primary weight bearing rising and standing—
right leg and foot ✕
sits on right pelvis Δ L ↓ balance
bends from mid thoracic ✕
breath moderately shallow and rapid Δ L & even
mild to moderate segmental movement—left ribs
with deep inhalation Δ smooth
P: moderate right frontal torsion Δ L
moderate plus bilateral sphenoid compression Δ M⁻
mild plus adhesion tentorium ✕
cranial rhythm moderately weak right Δ L
mild left Δ Normal

Modalities: Applications/Locations

97140 Lymph Drainage—trunk
60 min. Craniosacral—head
Feldenkrais—eyes and feet

Response to Treatment (see Δ)



A Goals: Long-term/Short-term

LTG: Lift granddaughter at least 10 times per day from the floor and carry her for 10 minutes with mild pain and fatigue 5 days per week in 60 days
STG: Lift light weight toys from floor 10 times per day 3 days per week in 2 weeks with mild pain

Functional Outcomes

P Future Treatment/Frequency

2 times per week for 3 weeks, 60 min. sessions, continue with lymph drainage, craniosacral and Feldenkrais, focus on ribs, diaphragms, increase mobility and decrease adhesions

Homework/Self-care

continue using heat on mid back but avoid it on neck and low back—switch to ice. Deep breathing exercises

Provider Signature JO, LMP, GCFP Date 2-6-17

Legend: ⊂ TP • TeP ○ Ⓟ ✳ Infl ≡ HT ≈ SP
✕ Adh ≋ Numb ⟲ rot ⟋ elev ⊢ Short ⟷ Long

- Discuss and create functional goals—after the initial assessment and treatment—that can be used as a measurement of the success of the relationship in language to which the patient can relate
- Determine the treatment plan that will best address the needs of the patient and move toward accomplishing the goals

Subsequent notes are brief and primarily record the treatment provided. The focus is on the patient's immediate presenting concerns with consideration to the proposed treatment plan. The notes are less comprehensive in regards to assessment and are more specific to the data directly related to the treatment provided. For example, on Darnel's initial session note, all cervical actions and ROMs were tested and recorded. On a subsequent note in which the focus of treatment was to decrease neck stiffness, only the cervical active ROM for lateral flexion was tested, charted, treated, and retested. The intent is to spend more time accomplishing goals than assessing the condition and determining the plan. The treatment plan is projected initially and reviewed during reevaluation sessions. Subsequent sessions carry out the treatment plan. The chart should reflect that and not repeat the goals or treatment plans unless changes are necessary. Often, the assessment and plan sections of the SOAP chart are left blank on subsequent notes. The assessment section should only reflect functional outcomes or changes to the goals. The plan section in a subsequent note needs to chart only additional homework assignments or self-care education, unless the treatment plan needs to be altered. A shorter version of the initial SOAP form is adequate for recording information between the initial visit and the reevaluation sessions (see Figure 6-8). In the EHR, you may skip the pre- and postsession measurement scales and leave them for the reevaluation sessions. This is best if the patient is generally healthy or has a chronic condition where change is not as noticeable in the short term.

Progress notes are used to chart reevaluation sessions. Reevaluation sessions are nearly as extensive as initial visits. Time is spent assessing progress, setting new goals, and creating new treatment plans. Schedule reevaluation sessions at every 6–8 visits and document them thoroughly. The notes for these sessions should be comprehensive and include a full-body evaluation.

Address everything mentioned in the initial note. There is no need to introduce new assessment tests unless new symptoms arise. It is critical, however, to revisit all previous assessments, even if the corresponding symptoms are no longer an issue. The intent is to put to rest some data and to measure the progress of the remaining data. For example, initially, Darnel had moderate, constant, low-back pain; moderate, frequent headaches; and mild, constant neck stiffness. Thirty days later, in the first progress note, Darnel reported moderate, constant, low-back pain; mild, intermittent headaches; but no neck stiffness. (It is important to record the fact that there is no neck stiffness.) Without a record of that information, one could question whether the neck stiffness was resolved or whether or not the practitioner simply forgot to note its existence. Once a symptom or objective finding is noted as a nonissue, it does not need to be revisited in any future progress note unless the symptom or finding returns.

The intent of the progress note is to present a complete, current picture of the patient's health. A comparison of the initial note and a progress note (or two consecutive progress notes) will provide summary information for **progress reports**, which are typed on letterhead stationary or built in the EHR and sent as a courtesy to referring the HCP. Progress notes are recorded on the extended version of a SOAP form on paper or on a treatment session note in the EHR and are similar to the initial session note (see Figure 6-9).

Progress reports can be built in the EHR quickly and easily. Systems are typically set up with reporting features that allow you to select the information to be included. The

FIGURE 6-8. Subsequent SOAP Chart: Paper Version

HANDS HEAL

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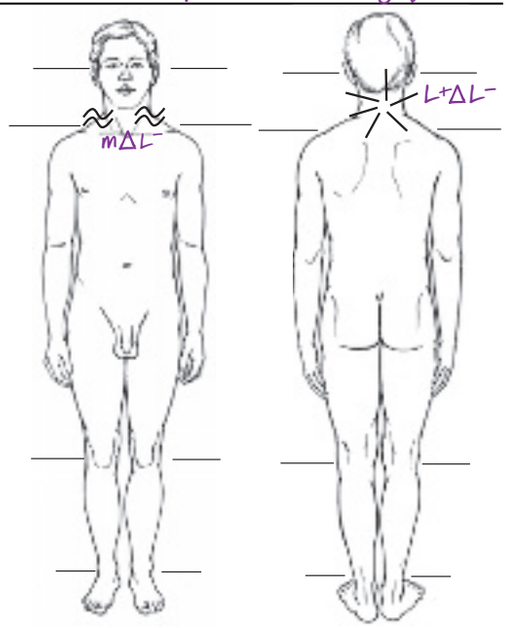
SOAP CHART-M

Patient Name Darnel G. Washington Date 2-8-17

Date of Injury 1-6-17 ID#/DOB 123-45-6789 Meds hydrocodone 500mg q4h

S Focus-decrease pain in head and neck



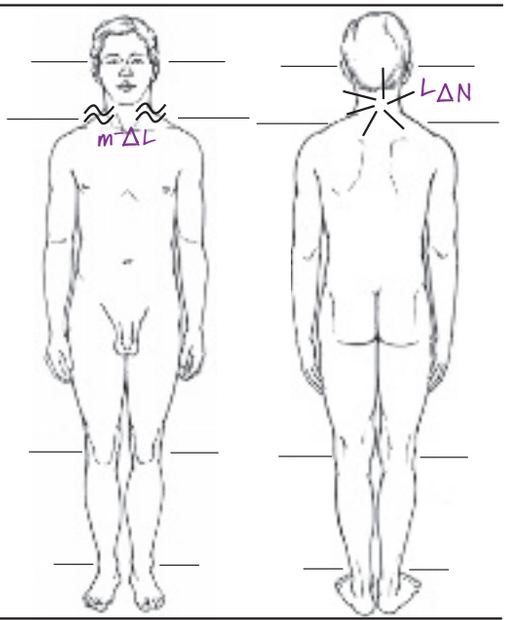
O 97140 60 min
Lymph Drainage neck, head

A F.O.-lifting lightweight toys from shelves with moderate pain

P having good success with ice and breathing exercises con't as instructed

Provider Signature JO LMP GCFP Date 2-8-17

S Focus-decrease pain in head & neck



O 97140 60 min
Lymph Drainage neck, head, chest, arms,
all passive cervical ranges of motion limited-mild minus-with mild pain at end ranges Δ N
with L⁻ pain

A con't

P con't

Provider Signature JO LMP GCFP Date 2-11-17

Legend: ⊚ TP • TeP ○ Ⓟ ✳ Infl = HT ≈ SP
╳ Adh ≫ Numb ⟲ rot ⁄ elev ⟝ Short ⟷ Long

FIGURE 6-9. Progress SOAP Chart with Discharge Plan

HANDS HEAL

John Olson, LMP, GCFP
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SOAP CHART-M

Patient Name Darnel G. Washington Date 1-20-18

Date of Injury 1-6-17 ID#/DOB 123-45-6789 Meds ⊖

S Focus for Today decrease stiffback

Symptoms: Location/Intensity/Frequency/Duration/Onset

Stiff mid back mild constant for 4 days since bridge marathon last weekend Δ within normal limits

Activities of Daily Living: Aggravating/Relieving

A: carrying granddaughter more than 10 minutes sitting or gardening for more than 2 hours ↑ Ⓟ to moderate
R: exercises, stretching, rest

O Findings: Visual/Palpable/Test Results

moderate weakness with sitting Δ L
moving from mid thoracic instead of hips
rib mobility moderately decreased Δ L
breathing restricted-mild Δ N

Modalities: Applications/Locations

97140 Feldenkrais-ribs and thoracic spine
60 min. Craniosacral-spinal traction and unwinding

Response to Treatment (see Δ)

A Goals: Long-term/Short-term

all goals have been reached within the limits of current health condition

Functional Outcomes

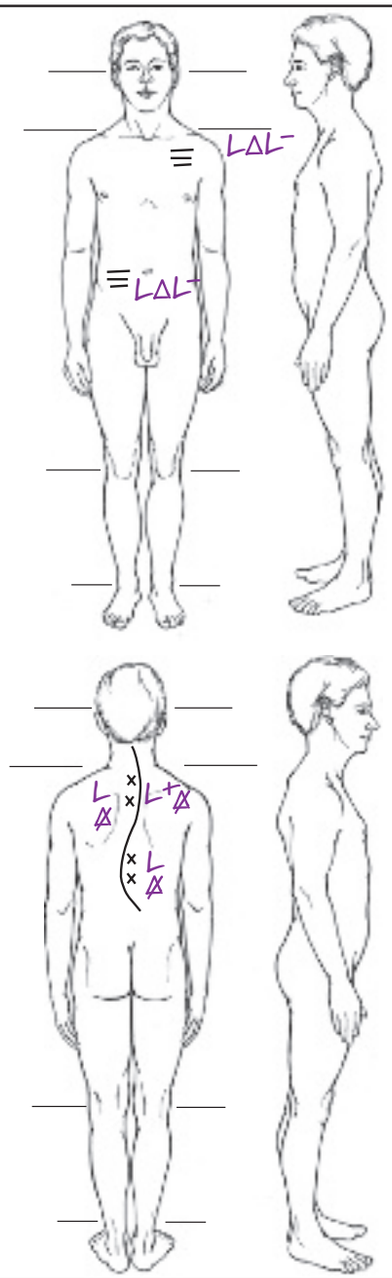
has not regained prior functional status since car accident 1-6-01
(note activities of daily living listed above)

P Future Treatment/Frequency

continue awareness through movement classes once per month, more often as needed, released from care and referred back to Dr. Redtree.

Homework/Self-care

Remember to breathe and roll ribs when sitting for long periods- take breaks and do exercises before stiffness sets in



Provider Signature JO LMP GCFP Date 1-20-18

Legend: ⊜ TP • TeP ○ Ⓟ ✳ Infl ≡ HT ≈ SP
× Adh ≋ Numb ⟲ rot ⟋ elev ⊢⊣ Short ⟷ Long

Hands Heal EHR has a section for writing the summary, where you can write either a short progress summary for an identified section of the treatment series or a lengthy narrative report summarizing from beginning to end. The rest of the content requires a simple click to include or hide. Then create a pdf to send it electronically (see Figure 6-10).

TALES FROM EXPERIENCE

Assessment Is Treatment

A manual therapist in the San Francisco Bay area conducted a case study of all her patients to investigate the impact of information gathering on the patients' health. In every session over a one-year span, she began with ROM testing. After recording the results, she continued to gather data, inquire about how patients felt and how their lives were affected by the symptoms, and record postural and palpation findings. After 10 minutes of information gathering, she repeated the ROM test. Surprisingly, the simple act of observing and recording patients' concerns resulted in a 50% improvement, on average, in ROM. As the therapist, it is important to believe that the treatment time is well spent. Many feel the interview is not considered part of the treatment. This statistic may also convince patients—who are reluctant to take time away from the hands-on portion of the session—of the importance of information gathering and charting.

On completion of the therapeutic relationship or when the transition is made from treatment massage to wellness care, **discharge notes** are recorded. These include a final summary of the patient's progress, health status, and any subsequent course of action. Use the same SOAP form you used for the progress notes and adapt the plan section to cover discharge data. In an EHR system, use the additional comments section to record discharge information or build a progress report to share with the referring HCP. Write the reasons for discharge, such as sessions reached limits of referral, patient met goals for care, or patient reached plateau in progress, in place of the treatment plan. Ongoing care may be required to maintain the progress established. Document any further action to be taken by the patient. Record the self-care regimen you recommend, suggestions for additional care, and any referrals to other caregivers or back to the referring HCP (see Figure 6-7).

Discharge notes include the following:

- Current health status
- Summary of treatment
- Summary of progress
- Reason for ending care
- Recommendations for ongoing care
- Referrals

Timing

Charting may feel time-consuming at this point. You may be just beginning to chart or you may not have charted this extensively before. Charting may feel burdensome until it becomes habitual and you memorize the standard abbreviations. In time, you can expect

to spend considerably less time charting outside each appointment time. Most charting occurs during the session with your patients. Charting in your patients' presence includes them in the healing process and helps you incorporate their input and focus on their goals. Do this to ensure patient-centered care, accuracy, and completeness and present an air of professionalism.

Write down subjective and objective information as you gather it from the patient. If you are performing hands-on tests or evaluating data at pretreatment, during the massage, or in posttreatment take breaks to record information. Recording information as you go will prevent you from forgetting data and will give the patient time to rest and integrate your treatment. When using an electronic system, make sure you save often.

FIGURE 6-10. Electronic Health Record Progress Report

Hands Heal™ EHR

Progress Report
Massage Therapist: Diana Thompson
NPI #: 1467516849

Hands Heal
3302 Fuhrman Ave E Suite 110
Seattle, WA 98102
Phone: (206) 755-5564

Client Info

Jackie Phillips
1234 56th st
Seattle, WA 98100
(206) 555-5543
Jackie@gmail.net

Health Info

Knee pain, foot pain, both worse in past year

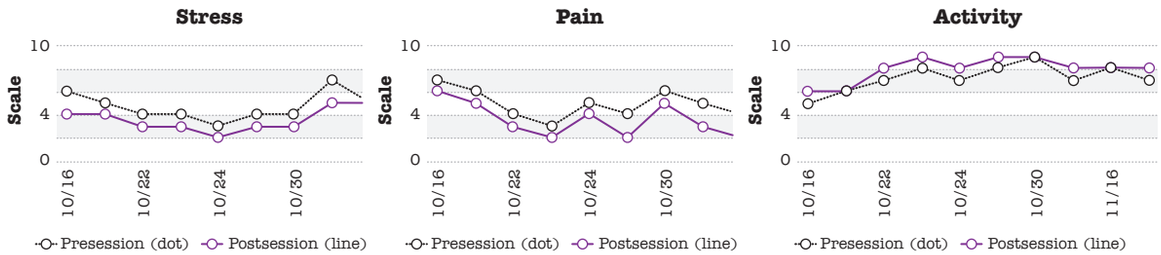
Health History

MVC 2014, Dx severe herniation L-4/5, four knee surgeries over past 20 years, high blood pressure, on statin and supplements, competitive athlete since school through 40s.

Report Summary

Ms Phillips presented with bilateral knee and foot that prevented many activites, limiting walking, climbing up and down stairs, and weightbearing exercise. With regular massage therapy, an anti-inflammatory diet, and a cautious increase in exercise, Ms Phillips can now ride an elliptical for 15 minutes, and can walk around the track for one mile without increased pain.

Progress



Session History

Date	Pre-Session Scales			Treatment Notes	Post-Session Scales		
	Stress	Pain	Activity		Stress	Pain	Activity

To meet HIPAA (Health Insurance Portability and Accountability Act) regulations, many systems will log out automatically after a set amount of time to protect patient confidentiality.

After the session is over, review the goals and write new ones that have arisen. Evaluate the progress and share feedback. Sharing the results of the session aloud immediately after the treatment assists the patient in integrating the results, verbalizing his or her needs for the session, and formulating ideas for future solutions. Discuss homework options and write down all assignments. Record the results of the session and status of the goals, write new goals, and work out the treatment plan together before the session ends.

The only thing left to do after the patient leaves is to review the subjective and objective data and fill in any details that will assist you in remembering information for the next session or for report writing in the future. Otherwise, all charting is a part of the session and is done in the patient's presence.

Remember, chart extensively every 30 days. Prepare your patients for these comprehensive evaluation sessions by telling them at the initial session what they can expect from the series, including how you work, the importance of gathering information, and how the feedback from the evaluations shapes your treatment plan (and ultimately the results). Impress on them the importance of the information on your ability to be effective and efficient with your massage, and they will look forward to the information they receive from the assessments you provide.

Summary

Session notes are a valuable and necessary component of all manual therapy sessions. SOAP charting is a standard format routinely used by medical, chiropractic, and allied health professionals for documenting health care sessions. SOAP is an acronym that stands for

- Subjective—data provided by the patient (symptoms and functional limitations)
- Objective—data from the practitioner's perspective (movement tests, palpation findings, visual observations, and treatment and the patient's immediate response to the treatment)
- Assessment—functional goals and outcomes based on activities of daily living
- Plan—treatment recommendations and self-care education

Documentation guidelines include the following:

- Be attentive and practice good listening skills.
- Be clear and concise.
- Measure everything.
- Be specific—avoid vague statements such as improved, better, or less pain.
- Use consistent terminology.
- Chart information pertinent to patient's health.
- Be objective.
- Record positive and negative findings.
- Use common medical terms and standard abbreviations.
- Never use correction fluid or eraser to eliminate information.

- Sign or initial each entry with your legal name and credentials.
- Cosign for students, aides, and apprentices.
- Write legibly.
- Print (or stamp) your name, address, and phone number on each page in the file.

Use a functional outcomes style of reporting information. Set LTGs and STgs that will clearly demonstrate functional outcomes. Follow SMART criteria for functional goal setting. The SMART acronym stands for

- Specific—to an ADL.
- Measurable—quantify and qualify results to measure progress.
- Attainable—success is probable given the patient's condition, constitution, and attitude.
- Relevant—activity is critical to patient's ability to earn a living or care for self, family, or household.
- Time-bound—success within a specified time—LTGs (typically 30–60 days) and STGs (generally about 1–2 weeks).

Describe the symptoms in detail in the subjective section of the session note.
Describe the symptom.

- Note the location.
- Rate the intensity.
- State the duration and frequency.
- Give a detailed description of the onset on the initial SOAP note.
- Record functional limitations.
- Identify daily activities the patient can no longer do or cannot do without increasing symptoms.
- State the patient's previous ability to perform the activities listed.
- State, in measurable terms, the patient's current situation regarding the activities.
- Record activities that relieve the patient's condition.

Follow these guidelines for documenting objective data.

- Document the full range of data.
- Measure every finding.
- Base measurements on deviations from normal by (1) making bilateral comparison when possible, (2) defining normal for a general population of similar constitution, and/or (3) asking patients to define normal for themselves.
- Measure the data before and after treatment.
- Perform the preevaluations and postevaluations identically.
- Chart posture and movement by (1) noting the position of the patient, (2) noting the angle of the observation, and (3) describing the activity.
- Chart palpation by (1) identifying the specific location, (2) rating or describing the touch that triggers the finding, (3) including referred sensations, and (4) identifying connections or relationships between findings.
- Chart the ROM test by (1) identifying the position of the patient, (2) identifying the type of test, (3) naming the joint, and (4) naming the action.
- Chart the results of the ROM test by (1) rating the amount of movement, (2) rating the pain associated with the movement, and (3) rating the quality of the movement.

There are four types of session notes (see Figure 6-11) as follows:

- Initial—comprehensive, prioritized list of concerns or desired results of the sessions, full-body evaluation, projected goals, and treatment plan.
- Subsequent—focus on treatment, address current concerns and STGs and site-specific evaluation.
- Progress—comprehensive review of concerns, full-body evaluation, progress evaluation, and goals and treatment plan reestablishment.
- Discharge—evaluate the full body evaluation, summarize health status, summarize progress and functional outcomes, state reason for discharge, make recommendations for ongoing care.

Chart throughout the session in the presence of the patient to prevent charts from piling up on your desk. Memorize abbreviations and, in time, you will become fast and efficient at documenting treatment sessions.

FIGURE 6-11. Types of SOAP Charts: Comparisons of Content

	Initial (First visit)	**Subsequent**	**Progress** (every 30 Days)	**Subsequent**	**Discharge** (last treatment)
S	All Health Concerns **ALL** Symptoms **ALL** Activities of Daily Living	Tx Focus Sx: significant changes only ADLs: significant changes only	Remaining Health Concerns **ALL** Sx **ALL** ADLs	Tx Focus Sx: significant changes only ADLs: significant changes only	Remaining Health Concerns **ALL** Sx **ALL** ADLs
O	**ALL** findings: Visual, palp., mvmt Tx, Δ	findings: significant changes only Tx, Δ	**ALL** findings Tx, Δ	findings: significant changes only Tx, Δ	**ALL** findings Tx, Δ
A	Long-term goals (LTG) Short-term goals (STG)	Functional Outcomes (FOs)	New LTG STG (s)	FOs	any remaining LTG summarize FOs
P	tx plan Homework Selfcare Ex (HW/SC)	HW/SC	New tx plan HW/SC	HW/SC	referral back to HCP long-term HW/SC

The → means that all data on the previous chart must be addressed in the current chart.

References

1. Kettenbach G. *Writing Patient/Client Notes: Ensuring Accuracy in Documentation*. 5th ed. Philadelphia: F. A. Davis; 2016.
2. Dillon DQ. *Charting Skills for Massage Therapists: A Self-Study Workbook*. St. Catharines, ON: MT Coach; 2007.
3. Rose MK. *The Art of the Chart: Documenting Manual Therapy with CARE Notes*. Massage and Bodywork Quarterly; April/May, 2003.
4. Bickley LS. *Bates' Guide to Physical Examination and History Taking*. 12th ed. Philadelphia: Wolters Kluwer; 2016.
5. Adler RH, Giersch P. *Whiplash, Spinal Trauma and the Chiropractic Personal Injury Case*. Seattle: Adler Giersch; 2004.
6. Magee DJ. *Orthopaedic Physical Assessment*. 6th ed. Philadelphia: WB Saunders; 2008.
7. Travell J, Simons D, Simons L. *Myofascial Pain and Dysfunction: The Trigger Point Manual*. Baltimore: Williams & Wilkins; 1999.
8. Chenkin DC, Eisenberg D, Sherman KJ, et al. Randomized trial comparing traditional Chinese medical acupuncture, therapeutic massage, and selfcare education for chronic low back pain. *Arch Intern Med*. 2001;161:1081.
9. Kendell FP, McCreary EK, Provance PG. *Muscles: Testing and Function*. 5th ed. Baltimore: Williams & Wilkins; 2005.
10. Norkin CC, White D. *Measurement of Joint Motion: A Guide to Goniometry*. 5th ed. Philadelphia: F. A. Davis; 2017.
11. Weaver R. *The Touch Factor Foundation Manual*. Montana: Weaver; 1997.

CHAPTER 7

Wellness Charting for Massage and Bodywork Therapies: Energy Work and Relaxation Therapies; Event, On-Site, and Spa Venues

After mastering the concepts in this chapter, the student will be able to:

- Identify the basic content of a wellness chart
- Discriminate between patients that require wellness charting and those that require treatment notes
- Formulate customized wellness notes based on the venue for quick and easy wellness charting

Sinan has been receiving massage therapy weekly at the Healing Arts Clinic. He never mentioned to his massage therapist, Louise, that he had been in a car collision. It wasn't a secret; he just didn't remember her asking. Sinan was sure his car insurance would not cover massage because his doctor wouldn't prescribe it. Sinan knew he needed something to loosen up his tense muscles and decided to pay cash for his weekly massages.

Sinan responded well to his therapy. Louise combined relaxation techniques with deep tissue massage, stretching, and movement to increase mobility, loosen tight muscles, and help Sinan feel better. He believed massage was helping him recover from his car collision as well as obtain his other goals for health.

A year after his car accident, after prompting from his attorney, Sinan asked the receptionist at the Healing Arts Clinic for copies of his massage records. His attorney wanted to include the massage records and bills in the settlement package for his personal injury lawsuit. The attorney intended to use the records to substantiate Sinan's injuries and to strengthen his lawsuit with the bills and documented proof of out-of-pocket expenses Sinan had incurred as a direct result of the collision. Sinan hadn't specified any health complications and wasn't referred by a doctor. With no insurance company paying for the sessions, Louise had chosen not to document any of the sessions. The receptionist didn't have any records on Sinan except cash receipts. Without documentation, Sinan's lawyer was unable to establish a connection between the massage sessions and the injuries from the car collision. Therefore, Sinan was unable to get reimbursed for the thousands of dollars he spent on massage, even though the therapy was instrumental in his recovery.

One afternoon, Louise was attending a consult session at the Healing Arts Clinic with the other practitioners in the clinic. She was sharing her fear of losing her steady client, Sinan. Sinan had been coming one to two times per month for a few years, and she didn't think anything of it when he started scheduling weekly sessions. She recently learned that this was because he had been in a car collision but didn't alert her. Jamie told a similar story: A woman named Claire had been a client for many years, coming monthly for relaxation massage. Then, 3 months ago, she was injured at work. Claire's insurance company refused to pay for her massage therapy. The insurance adjuster claimed that because Claire had been seeing a massage therapist before the injury, she must have had preexisting conditions that required her to continue receiving massage treatments. Therefore, the massage therapy was not necessary for treating the recent injury.

Claire asked Jamie for her records so that she could prove to the insurance company that she had been in excellent health until the injury. However, Jamie had no records of the massage sessions. Even though Claire had been healthy and received massage only for relaxation, there was no documentation to prove that to the insurance company. Claire was stuck with the bills.

Jamie and Louise shook their heads in dismay. Initially, they had been under the impression that only insurance-paying patients required documentation. Gone were the days when relaxation therapy was an excuse not to do paperwork. They made a pact with each other to better serve their clients and themselves by charting all sessions. It no longer mattered whether the session was for relaxation or injury treatment or whether payment came from an insurance company or from the client; they were going to keep records on every client and document every session.

Introduction

Clear and consistent written communication does not have to be complicated. It needs to flow naturally and become a part of the healing atmosphere and the tender care you provide your client. This task is easily incorporated if the benefits are evident with each return visit. Every word that is written, when reread before the next session, can teach you how to better understand the needs of the client and deliver a customized session that keeps them coming back. If you can accomplish this, then you will have no problems keeping written, legal documents that benefit you and your clients, inform the health care team, and keep the money flowing.

SOAP (Subjective, Objective, Assessment, Plan) **charting** assists practitioners in solving patients' medical problems. Yet, not everyone seeks manual therapy to treat an injury or care for an illness. People in good health often receive manual therapies for any number of reasons, such as to relax and reduce stress, to experience healthy touch, or to detoxify and tone the skin.

If SOAP charting, or other format for documenting treatment sessions, is used when assessing and treating medical problems and the client has no preexisting conditions or current complaints, is the practitioner obligated to keep a medical record?

Yes. Manual therapy is considered a health care modality and practitioners are licensed, certified, or regulated in varying capacities throughout the United States and other countries. If you are practicing massage, bodywork, or movement therapies in a state or province that does not regulate manual therapists as health care practitioners, simply ask your clients whether or not they feel your sessions assist them in keeping with their goals for health. Research suggests that they will say yes almost every time. In an AMTA (American Massage Therapy Association) consumer survey conducted in 2015, 88% of the respondents view massage therapy as beneficial to overall health and wellness and 71% believe massage therapy should be considered a form of health care.[1]

Unequivocally, manual therapy makes our bodies feel better and improves our outlook on life. As a result, we may need to adopt the standards of the health care profession until the individual state laws catch up with our professional values. (As of this printing, 46 states regulate massage therapy, about twice as many as when this book was first published.)

In keeping with health care standards, manual therapists must record information about their clients' health and the services provided. Obviously, treatment for healthy or injury-free clients may not require extensive documentation on a SOAP note, as would charting patient symptoms and pathophysiologic findings. Documenting manual therapy sessions for healthy clients is brief in comparison, and the format can be tailored to specific environments, such as spas, airport concessions, and sporting events.

FROM THE LITERATURE

Cost Benefits of Wellness Programs

More and more studies are showing a measurable return on the investment to instill a culture of wellness in the workplace.

A National Business Group on Health, Towers Watson Staying@Work Survey, 2013/2014 was completed by 892 employers. Companies with highly effective health and productivity programs have strong human capitol and financial results when compared to low-effectiveness companies:

- **Obesity rates that are 25% lower**
- **Diabetes/glucose rates that are roughly half**
- **Lower unplanned absences**
- **Higher financial productivity**
- **Differential in annual health care costs of more than $1600 per employee[2]**

In a meta-evaluation of worksite health promotion programs, programs were found to improve health and lower costs. One company reported an annual savings of $613 per participant. Another reduced back injuries, saving the company over $800,000. A third's program was likely responsible for decreasing absenteeism, reducing costs by about $15.60 for every dollar spent on the program.[3]

Wellness Format for Documenting Healthy Clients

A simple system for documenting healthy client sessions is the wellness chart, the paper version of which is included in this book. A wellness chart contains a brief intake questionnaire for gathering health history information (Hx) and for recording the treatment provided (Tx). Additional information, such as personal preferences, variations from the routine, or client progress, can be recorded under comments (C). The figures are optional and are useful for charting the therapist's findings, such as muscle tension and postural deviations for clients receiving ongoing care. Three styles of wellness charts are provided in this book: (1) standard charts for relaxation, spa therapies, and energy work; (2) seated charts for on-site sessions; and (3) sports charts for sporting events (see online, Appendix A for blank forms).

The EHR (electronic health record) version of a wellness note is similar. The EHR automatically records the date at the top, and the wellness note includes the three basic required categories: how long you worked (duration), where you worked (position/location), and what you did (techniques). The presession measurement scales that the client completes before the session include a section to update their health status and gather current client complaints on the scales (stress, pain, and activity level). The postsession measurement scales chart any progress as a result of the session (see Figure 7-1).

There are only two requirements for charting wellness sessions. First, an adequate health history to ensure the client's safety (see Chapter 5, Documentation: Intake Forms). Second, a detailed record of the therapy provided. Wellness charts provide a historical

record of wellness and health challenges over time and recount the role of the manual therapist in the client's progress toward health. The three components of charting the session are as follows:

- Type of manual therapy—techniques and modalities used
- Location—areas where manual therapy was applied
- Duration—length of session

Treatment options can be provided, allowing the practitioner to simply check off or circle answers. Narrative charting is often too time-consuming for fast-paced environments with high turnover. One way to speed up charting is to provide predetermined options for treatment routines on customized wellness charts. For example, preevent and postevent may be the only treatment description you need when charting massage for a sporting event; seaweed wrap, mud pack, or herbal moisturizer for a salon; stress buster, smooth and soothe, or energizer for an airport concession. Time can be noted in 15-minute increments. Location of treatment can be simplified with a checklist (see Figure 7-2) for full body (FB), upper extremities (UE), lower extremities (LE), upper trunk (UT), and lower trunk (LT). Customize your chart to fit your practice.

As discussed in Chapter 5, Documentation: Intake Forms, health information forms are completed annually. Modify the paper version of the wellness chart for repeat clients by adding additional pages that replace the health history with multiples of the treatment (Tx)

FIGURE 7-1. Wellness Chart—Electronic Health Record

Date: 4/1/2017 **Massage Therapist: Diana Thompson** Hide

Presession Information

Stress Scale: 1
Working on a deadline

Pain Scale: 1
stiff and sore between shoulder blades

Activity Scale: 9
I am needing to take more breaks than usual at my desk due to stiffness and eyestrain

Health Status:

Notes

Wellness –

Duration: 60 (minutes)

Treatment Position/Location
Prone, supine, FB massage with focus on midback and shoulders

Treatment Techniques
MFR, AIS

Treatment +

Postsession Information

Stress Scale: 0

Pain Scale: 0

Activity Scale: 10

Feedback/Comments
Feel like new! Thanks.

and comments (C) section. Four sessions can be recorded on each page (see Figures 7-3A and 7-3B). The figures make this is a quick and easy way to create a picture of your client's health over time, highlight problem areas, and demonstrate steady progress at a glance.

Treatment Charting Versus Wellness Charting

With each new client, determine whether a treatment note is necessary or whether a wellness chart can be used. The question is not whether to document but rather which documentation format to use—SOAP, CARE, wellness, narrative, EHR, or another. It is *always* necessary to chart manual therapy sessions. Here are the factors to consider when selecting one style of documentation over another:

- Client health
- Client expectations
- Goals of treatment
- Treatment results
- Reimbursement for services

GUIDELINES FOR SELECTING A TREATMENT NOTE

Use a treatment note format whenever extensive documentation is necessary. If any one of the following statements apply, use the standard SOAP format or an EHR treatment note to document the treatment (see Chapter 6, Documentation: Session Notes, for in-depth information on SOAP charting).

- The patient has health problems or symptoms and is seeking treatment to relieve them.
- A doctor referred the patient for treatment.
- Insurance is involved in reimbursement.

FIGURE 7-2. Customized Spa Wellness Chart—Treatment

3. Are you allergic to any of the following? (Please circle all that apply.) Almond Oil, Aloe Vera, Cucumber, Honey, Lavender, Milk, Mud, Olive Oil, Sandalwood, Seaweed.

4. I have provided all my known medical information. I give my consent to receive treatment.
Signature _____ Date _____

Tx: ☐ body scrub ☐ herbal wrap ☐ Swedish massage ☐ mud pack

☐ FB ☐ UE ☐ LE ☐ UT ☐ LT ☐ facial ☐ foot reflexology

C: _____

☐ 15 ☐ 30 ☐ 45 ☐ 60 minute session initials _____ date _____

FIGURE 7-3A. Seated Wellness Chart—Page 2

Provider Name

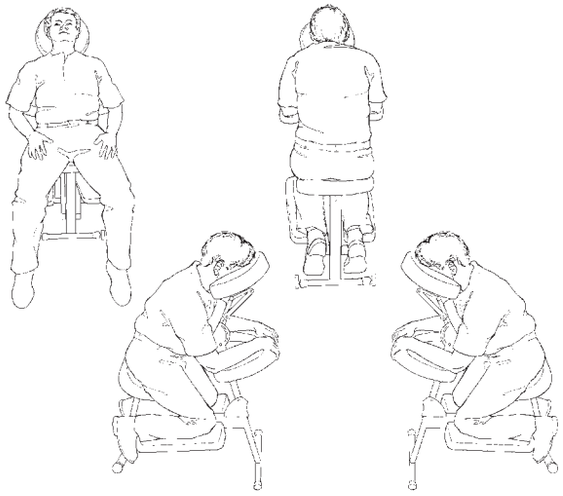
WELLNESS CHART—SEATED

Name _____ ID#/DOB _____ Meds _____

Phone _____ Email _____

Tx: _____

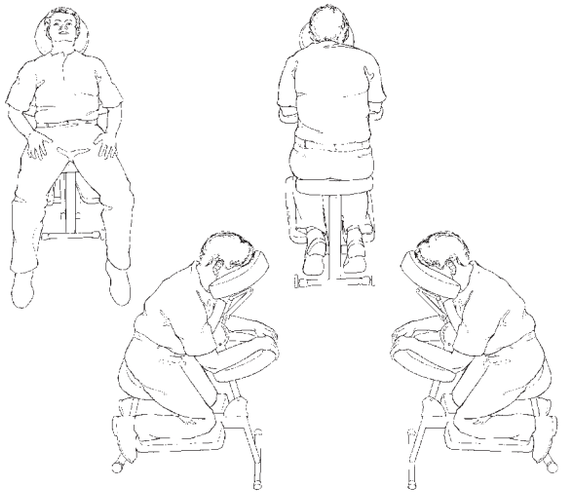
C: _____



date _____ initials _____

Tx: _____

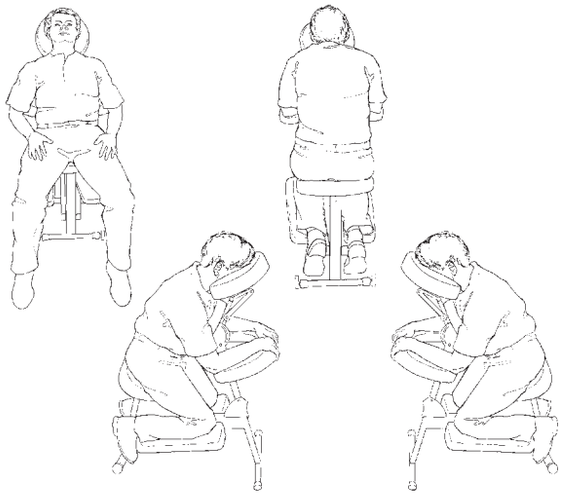
C: _____



date _____ initials _____

Tx: _____

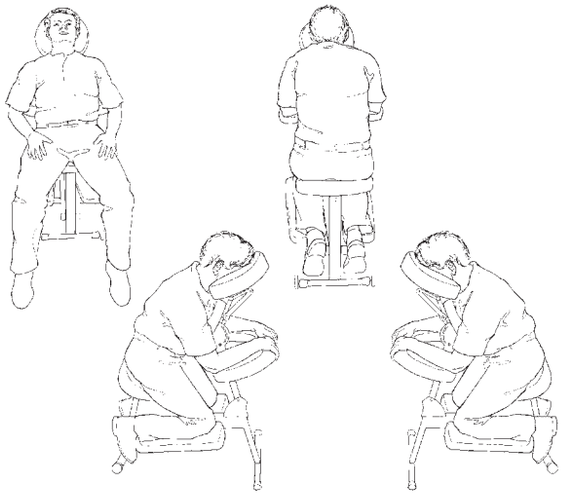
C: _____



date _____ initials _____

Tx: _____

C: _____



date _____ initials _____

Legend:

⊜ TP	• TeP	○ Ⓟ	✳ Infl	= HT	≈ SP
× Adh	≪ Numb	⟲ rot	/ elev	⟝ Short	⟷ Long

FIGURE 7-3B. Standard Wellness Chart—Page 2

Provider Name

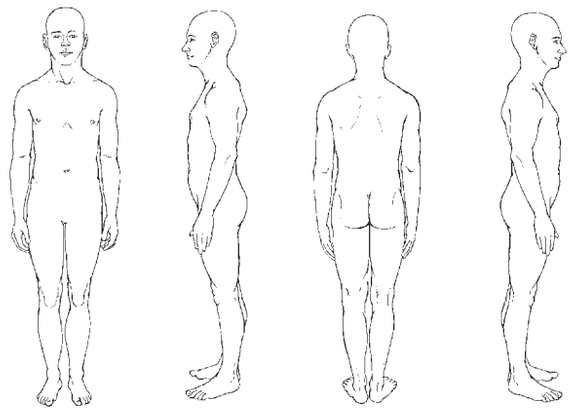
WELLNESS CHART

Name _____ ID#/DOB _____ Meds _____

Phone _____ Email _____

Tx: _____

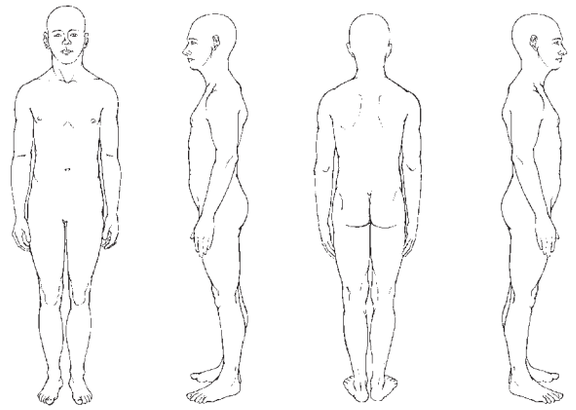
C: _____



date _____ initials _____

Tx: _____

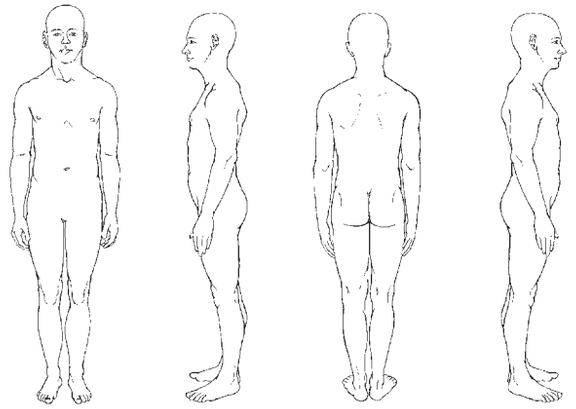
C: _____



date _____ initials _____

Tx: _____

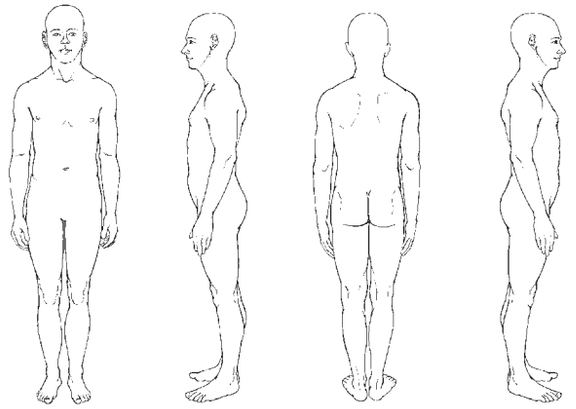
C: _____



date _____ initials _____

Tx: _____

C: _____



date _____ initials _____

Legend:

⌀ TP	• TeP	○ Ⓟ	✳ Infl	≡ HT	≈ SP
✕ Adh	≫ Numb	⬭ rot	⁄ elev	⟝ Short	⟷ Long

- The treatment provided varies from individual to individual and is based on patient symptoms, conditions, and practitioner findings.
- The treatment results are significant, specific, and measurable.

A treatment note is appropriate when the patient has health concerns that the manual therapist is expected to address during treatment. SOAP charts, for example, record subjective data such as patient symptoms, functional limitations, and objective data, such as inflammation, muscle spasms, trigger points, and the like. If the client is healthy, there may be no symptoms to report, no data to collect, and no medical condition to treat. However, clients have expectations that sometimes may be different than our own regarding treatment. For example, the therapist may believe he or she is providing manual therapy for relaxation, but the client may have selected the treatment specifically to heal a whiplash injury, as was the case for Jose. Remember to conduct a thorough interview, clarify client goals and place them above your own, and educate clients on your scope of practice. The key is to reach a mutual agreement regarding goals for health.

Always use a treatment note with patients who have been referred by a health care provider (HCP). Referring providers generally have a particular outcome in mind, making a thorough assessment warranted. You can always switch to a wellness chart once a patient reaches his or her goals for health or when you discover that the patient's health concerns are minimal and manual therapy is primarily indicated for stress reduction.

If the patient is seeking insurance reimbursement, gather information that will assist you in receiving payment for your services. Insurance plans typically state that treatment must be medically necessary. A thorough treatment note will provide the documentation required to prove medical necessity. If the client does not present with symptoms or functional limitations sufficient to validate a medical condition, chart the manual therapy sessions on a wellness chart rather than stretching the truth simply to fill a treatment chart. A common mistake when using a treatment note to record wellness care is to note tight muscles as moderately or severely hypertonic, even though the client's activity level is not affected by the tight muscle. It would be more realistic to note the tight muscles as mildly hypertonic: The tight muscle does not interfere with the client's ability to perform daily activities. Claire, in the opening story, was hoping for documentation affirming that her regular manual therapy was addressing minor tight muscles and stiff joints, not the injury treatment the insurance company inferred. A wellness note would have been perfect for that situation.

All manual therapy treatments should be modified to meet the needs of the client. The difference between a session that warrants a treatment note and one appropriate for a wellness note lies in the overall intent. Sessions where treatments vary constantly based on individual symptoms and findings and are applied with curative intent warrant a treatment note. For example, if cross-fiber friction is applied directly over scar tissue with the intent to decrease adhesions and increase mobility, the treatment is intended to ameliorate the condition and should be recorded on a treatment note. Manual therapy routines with wellness intent, which vary based on client preferences, safety and comfort, such as adjusting positions or providing a pillow, do not require a treatment note.

Treatment results that go beyond general therapeutic benefits, such as decreasing trigger point pain, balancing structural issues, or increasing range of motion limited by adhesions, should be substantiated on a treatment note. Document progress by measuring significant changes in subjective and objective findings. If, for example, you and your client initially determined that treatment was strictly for general health purposes—increasing relaxation, circulation, and mobility—and you have been using the wellness

charting method, switch to the SOAP format when you and the client determine that the goals of the therapy have changed and a clinical treatment protocol is currently needed.

Organize the charts in the client's file chronologically by date regardless of format. There is no need to keep treatment notes separate from wellness notes. It is acceptable to mix charting formats within a single file. Clients often fluctuate between wellness care and therapeutic treatment as their needs change and they reach their goals for health.

GUIDELINES FOR SELECTING THE WELLNESS FORMAT

Use wellness charting when the client is healthy, treatment is routine with wellness intent, and sessions do not involve ongoing, curative health care. Follow these guidelines for determining whether a session warrants this style of documentation:

- The client is healthy and has no specific health issues.
- If the client has health issues, the specific health conditions, symptoms, and findings are not addressed in the session, other than for client safety and comfort.
- Treatment is provided for general therapeutic benefits—such as improved circulation, relaxation, and mobility—without the intent or expectation of altering existing health conditions or symptoms such as localized pain, numbness, compensatory postural patterns, or limited mobility.
- The treatment is routine. The practitioner does not deviate from that routine, other than to ensure client preferences, safety, and comfort, regardless of symptoms and pathophysiologic findings.
- The client is not using the session as ongoing, curative health care treatment for a specific condition.

RELAXATION THERAPIES: TREATMENT OR WELLNESS?

More often than not, the intent of the treatment determines the documentation format. The style of therapy rarely dictates the documentation format. One research study showed that, when compared side-by-side, both general FB massage and massage concentrated on the painful areas improve chronic pain equally—with no statistically significant variation in results.[4] Drainage techniques applied as an FB routine with general circulatory benefits may warrant wellness charting; on the other hand, a drainage session designed to treat inflammation resulting from a swollen ankle warrants charting on a treatment note. Manual modalities, such as Trager, Swedish massage, and CranioSacral Therapy, can be applied with either curative or palliative intent. Follow the guidelines outlined earlier to determine whether to use treatment notes or wellness charting. Use the standard wellness chart for documenting most relaxation therapies (see Figure 7-4).

In many cases, the guidelines for determining charting format are easy to apply. However, situations exist in which the lines blur. For example, it is nearly impossible for many manual therapists to follow a relaxation routine and not address what they feel underneath their hands. If you find yourself treating specific findings and straying from a more general focus, note the variations from the routine and the objective findings in the comments section of the wellness chart. If the client returns for additional treatment and, together, you make the decision toward a more detailed treatment plan addressing health conditions, switch to a treatment note.

Relaxation is a general health benefit with widespread effects. Simple effleurage strokes can have profound analgesic benefits. Basic gymnastics can produce dramatic changes in mobility and function. Symptoms have been shown to resolve and illnesses,

FIGURE 7-4. Standard Wellness Chart—Relaxation—Page 1

Naomi Wachtel
567 Sunnydale Dr.
Flat Irons, CO 80302
PHONE 303 555 8866
EMAIL wachtel@email.com

WELLNESS CHART

Name Lin Pak ID#/DOB 5-31-69 Date 7-27-17

Phone (303) 555-0033x253 Address IBM 3rd Floor

1. What are your goals for health, and how may I assist you in achieving your goals? Limit long-term complications of diabetes through relaxation and stress reduction

2. List typical daily activities—work, exercise, home. I sit a lot at work and watch movies at home

3. Are you currently experiencing any of the following? If yes, please explain.

pain, tenderness	☒ No	☐ Yes:		stiffness	☒ No ☐ Yes:
numbness or tingling	☒ No	☐ Yes:		swelling	☒ No ☐ Yes:
allergies	☒ No	☐ Yes:			

4. List all illnesses, injuries, and health concerns you have now or have had in the past 3 years. (Examples: arthritis, diabetes, car crash, pregnancy) diabetes, borderline high blood pressure

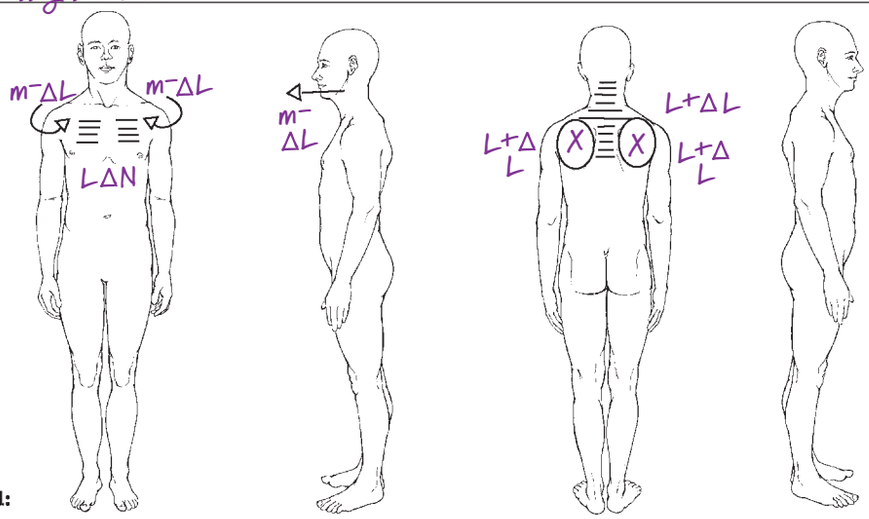
5. List medications and pain relievers taken this week. insulin

6. I have provided all my known medical information. I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment. I give my consent to receive treatment.

Signature Lin Pak Date 7-27-17

Tx: Full Body Swedish Massage, Lymph Drainage trunk and upper extremities 45-minute session

C: Homework-relaxation exercises, check blood pressure before and after massages at home



Legend:

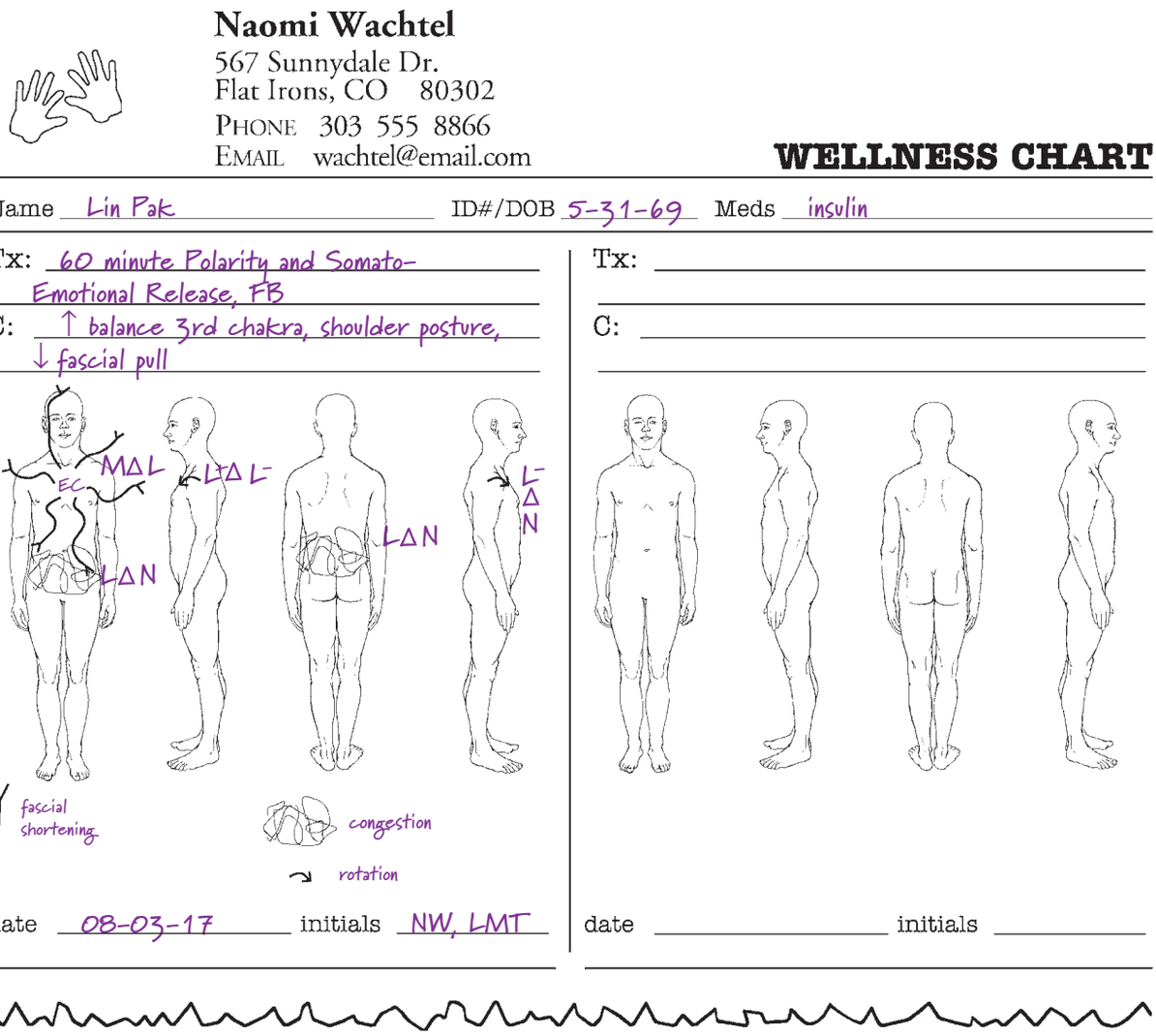
⊖ TP	• TeP	○ Ⓟ	✳ Infl	═ HT	≈ SP	initials NW, LMT
✕ Adh	≪ Numb	⟲ rot	⟋ elev	⟜ Short	⟷ Long	

to go into remission from healing touch.[5] The intent in providing an abbreviated format for charting is not to belittle the magnitude of hands-on healing but rather to provide an avenue for simplifying the paperwork when appropriate. Use the wellness format when the treatment is intended to be palliative rather than curative. If the results are more profound than anticipated, describe them in the comments section.

ENERGY WORK: TREATMENT OR WELLNESS?

Energy work, as with any other manual therapy, can be charted on either a treatment note or a wellness chart, depending on the condition of the client and the intent of the treatment. The difficulty in using a SOAP format, for example, to record energy work is one of language more than of style. Objective findings are not as tangible to the untrained hand or eye but are equally valid. The initial challenge is in coming up with a vocabulary to define what you feel and see and to use it consistently in a way that makes sense to others who may be untrained in energetic modalities. The list of abbreviations provided in this book contains standard symbols and abbreviations for energetic findings and treatment techniques (see online, Appendix D). Create an addendum for additional terms to fit your practice or list additional terms directly on the wellness chart (see Figure 7-5).

FIGURE 7-5. Standard Wellness Chart—Energy Work



Guidelines for documenting energy work: Follow the guidelines for selecting the style of documentation. If wellness charting is appropriate, chart the treatment routine and note the client's response to treatment in the comment section or near the data noted on the human figures (see Figure 7-5). If treatment notes are necessary, follow the guidelines presented in Chapter 6, Documentation: Session Notes. Here is a modified summary of the information in the previous chapter regarding the charting of energy work, using a SOAP format:

- S—Note subjective information, as defined in Chapter 6, Documentation: Session Notes (p. 127).
- O—Note objective findings specific to your energetic training. Emphasize physiologic findings. Use common terminology whenever possible.
  - O—State treatment location, duration, and modalities used. Highlight specifics.
  - O—State measurable changes in the subjective and objective data resulting from the session. Gauge the changes in intensity and quality of expression. Tell how the changes affect the client's quality of life.
- A—If the client's ability to function in everyday activities is impaired, set goals based on improving function, as defined in Chapter 6, Documentation: Session Notes (p. 142).
- P—Create a treatment plan and provide self-care instructions, as described in Chapter 6, Documentation: Session Notes (p. 145).

Energy work is rarely reimbursable by insurance companies and is considered experimental or investigational owing to limited research. This is also the case with many other manual modalities, even massage therapy. Lymphatic drainage is one of the few specific techniques to date with substantial international scientific evidence of effectiveness.[6] As a result, it is essential to demonstrate measurable progress based on function, symptoms, and physiologic findings for *all* manual modalities. When charting energy work—Reiki, Polarity, or therapeutic touch—or emotional bodywork, such as SomatoEmotional Release, Rosen Method, or Soma, emphasize the physical expressions of the energetic or emotional dysfunction. Highlight the results of treatment over the modalities used. Use terminology that is easily understood across professions.

Venues Befitting Wellness Charting

Wellness charting is appropriate for many venues. Two common ones are sporting events, where participants receive pre- or postevent therapy, and spas, and clients select from a menu of treatments designed for relaxation, detoxification, and beautification. The purpose of these sessions is specific to the venue, not to the individual, and the treatment routines do not vary much. Clients are not likely to depend on these for ongoing health care because the treatments are not tailored to meet individual needs but rather to address general therapeutic goals.

Each venue has specific documentation needs. The following will be addressed individually:

- Events—sporting events and health fairs
- On-site venues—business offices, malls, airports, and grocery stores
- Spas and salons

EVENT THERAPY

A common sight near the finish line at foot races or under a tent at street fairs is a large group of manual therapists with tables or chairs providing relief for participants. Manual therapy offered at venues such as these—sporting events, health fairs, and community events—require wellness charting. The pace is fast, the turnover is frequent, the sessions are brief, and the need to document is minimal. The charts will not become permanent records of the client's health, even though you are required to keep them on file for a length of time determined by the laws in your state, nor will the information be used for ongoing care, unless they become a regular client in your practice. However, the charts do assist the practitioner in determining whether treatment is appropriate, and they provide records that can become crucial if a client claims later to have been injured in the course of treatment.

Treatment provided at events meets the guidelines for wellness charting. At sporting events, the clients are healthy enough to be competing or walking long distances. Therapists are there to provide basic services and routine treatment. People are generally not seeking curative health care at these venues, and practitioners often do not have the time or information necessary to treat specific health conditions. Although therapists may use the event as an opportunity to market their practices, the treatment provided is likely to be the only treatment the client will receive from these therapists. If the client does seek out the therapist's professional services in the future, a formal intake will ensue and a decision will be made at that time regarding whether to use treatment notes or wellness notes for ongoing care.

Because the pace is fast and distractions are many at an event, read the intake questions out loud to the client. Make eye contact to ensure that the client is paying attention and understands the questions being asked. If a client answers yes to any of the questions, the practitioner must be prepared to ask additional questions that are not on the intake form to establish the appropriateness of treatment. For example, if a client says he has swollen feet, rule out infections and heart conditions that could be exacerbated by treatment. If a client was injured recently, determine the treatment methods that are most appropriate and decide whether treatment to certain areas of the body should be avoided.[7] If the venue is a street fair and alcohol is served, ascertain if the client has been drinking and if you and the client will be safe during and after the session. If a client has just finished a race and is exhibiting signs of shock, first aid should be administered immediately by trained medical staff. The intake information is brief but critical in event venues, as discussed in Chapter 5, Documentation: Intake Forms. Tailor your event wellness chart to the specific venue and include a checklist of treatment routines appropriate to the venue.

The nature of manual therapy at sports events is that there are no repeat visits. The event occurs once, or annually, and the tables or chairs are packed up and gone by the next day. As a result, several client sessions can be recorded on one form—individual client files need not be created—and filed by event date rather than client name. The intake questions are at the top of the form and are read to each individual. Space is provided below to record the client's name, the positive responses to intake questions, and the treatment provided, including modalities, location, and duration (see Figure 7-6).

ON-SITE MASSAGE

On-site chair massage is increasingly popular in work environments as an employee benefit. Many businesses recognize the detrimental effects of stress on job performance and long-term health[2,3] and offer on-site chair massage in an effort to keep productivity high and reduce sick leave.

FIGURE 7-6. Sports Chart

WELLNESS CHART—SPORTS

Provider Name Naomi Wachtel, LMT Date 8-4-17

Event Mountain Aid 10K Email wachtel@email.com Location Finish Line Tent

Ask each athlete the following: (Note individual responses below—concerns only.)

1. Are you currently experiencing any of the following?
   - pain, tenderness, stiffness
   - numbness, tingling
   - cold, clammy skin
   - swelling
   - dizziness
   - shaking
2. How soon do you compete? / When did you finish competing?
3. Have you warmed up? / Cooled down?
4. Have you consumed water since the event?

Athlete's Name Janelle Helm Athlete's initials: JH

Hx: (note concerns) No water-gave her 12 oz B&A tx

Tx: (check all that apply) _____ Pre-event 15 min Post-event _____ Refer-first aid/med

C: _____ Initials: NW, LMT

Athlete's Name Michelle Johnson Athlete's initials: MJ

Hx: (note concerns) ~~0~~

Tx: (check all that apply) _____ Pre-event 15 min Post-event _____ Refer-first aid/med

C: Focus on feet & legs Initials: NW, LMT

Athlete's Name Florence Thompson Athlete's initials: FT

Hx: (note concerns) ~~0~~

Tx: (check all that apply) _____ Pre-event 10 min Post-event _____ Refer-first aid/med

C: Focus on shoulders, UBack Initials: NW, LMT

Athlete's Name Sam Bailey Athlete's initials: SB

Hx: (note concerns) Spasm-Abd during tx

Tx: (check all that apply) Pre-event 5 min Post-event Refer-first aid/med

C: _____ Initials: NW, LMT

Athlete's Name _____ Athlete's initials: _____

Hx: (note concerns) _____

Tx: (check all that apply) _____ Pre-event _____ Post-event _____ Refer-first aid/med

C: _____ Initials: _____

Athlete's Name _____ Athlete's initials: _____

Hx: (note concerns) _____

Tx: (check all that apply) _____ Pre-event _____ Post-event _____ Refer-first aid/med

C: _____ Initials: _____

On-site chair massage differs from event therapies in one important way—the site is often permanent. On-site companies or individual practitioners contract with businesses for regular visits, which often are weekly. When chair massage—accessible, nonthreatening, and affordable—is a regular fixture in the work environment, clients who might not otherwise seek the services of a manual therapist may become repeat customers. A permanent site with repeat customers, many of whom have symptoms of repetitive stress conditions, presents some charting challenges, given the time constraints of on-site chair massage environments.

On-site chair massage, similar to event therapy, is fast-paced, has high turnover, and involves brief treatments. There is no time for extensive interviews, intake forms, or breaks between sessions for charting. However, the need for documentation is great. Charting must be quick and easy, and it must serve the needs of the client.

In an interview, David Palmer, often called the father of on-site chair massage, said, "I don't see on-site massage … too closely associated with healthcare services because it's not a treatment … It's not designed to fix anything. It's merely designed to make people feel better and to produce what I think is the greatest value of massage, which is to simply enhance circulation."[8] In such situations, a brief wellness chart is adequate. However, some people in the workplace have carpal tunnel syndrome, chronic headaches, or fibromyalgia. Many of those people use the on-site chair massage provided in their offices to treat their symptoms and to keep them functioning productively in the workplace. A record of their symptoms, physiologic findings, and progress could benefit practitioners and client alike. Demonstrating tangible results to business owners and to clients will increase customer satisfaction, demand, and availability.

The seated wellness chart (Figure 7-7) provides an alternative to the sports wellness chart. The primary addition to the chart includes illustrations of a person in a treatment chair. The practitioner draws symbols on the human figures, which allows quick charting of symptoms and objective findings and creates an easy reference for demonstrating progress and planning future treatments. The seated wellness chart contains an intake form, records measurable subjective and objective data, notes treatment routines, and provides space for additional comments from the practitioner.

Several treatments for the same client may be recorded on the second page of the seated wellness chart to prevent repetitive health information gathering (see Figure 7-3A). Other on-site venues—airports, convention centers, shopping malls, and grocery stores—are not prone to repeat clientele. The clientele is transient, the desire to receive treatment is spontaneous, and sessions are routine. Do not attempt to record repeat visits on a single form for this type of client. File charts by date, rather than by client name, and have each client fill out a new intake with each visit. Use the first page of the seated wellness chart for these venues or design a customized wellness chart that meets your individual needs.

SPA AND SALON SESSIONS

Spas are traditionally located in resorts, which cater to a transient population. Increasingly, however, spas are found in downtown areas, in urban neighborhoods, and inside salons. Salons are incorporating manual therapy and hydrotherapy services with traditional pedicures, manicures, and facials. Medispas are popping up—a hybrid between a medical clinic and a day spa that operates under the supervision of a medical doctor—and treat

FIGURE 7-7. Seated Wellness Chart—Page 1

Sarah Benjamin
123 Sun Moon and Stars Drive
Capitol Hill, WA 98119
PHONE 206 555 4446
EMAIL benjaimn@email.com

WELLNESS CHART—SEATED

Name Tham Maad ID#/DOB 12-19-86 Date 12-12-17

Phone ext 134 Address Microtech N. campus 2nd floor

1. What are your goals for health, and how may I assist you in achieving your goals? work without numbness, relax

2. List typical daily activities—work, exercise, home. computer, reading, skateboarding

3. Are you currently experiencing any of the following? If yes, please explain.

pain, tenderness	☒ No ☐ Yes:		stiffness	☐ No ☒ Yes:	R Sit
numbness or tingling	☐ No ☒ Yes:	R hand	swelling	☒ No ☐ Yes:	
allergies	☒ No ☐ Yes:				

4. List all illnesses, injuries, and health concerns you have now or have had in the past 3 years. (Examples: arthritis, diabetes, car crash, pregnancy) MVC Aug, 1914

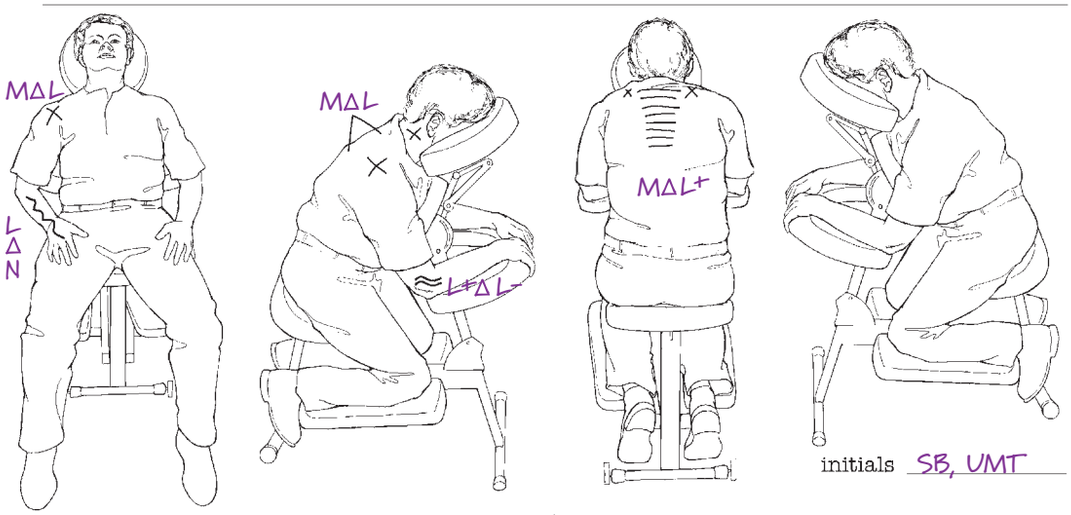
5. List medications and pain relievers taken this week. none

6. I have provided all my known medical information. I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment. I give my consent to receive treatment.

Signature Tham Maad Date 12-12-17

Tx: 30 min. SW (M) - Focus on (R) Sit, arm, hand, BL neck, chest, back, light pressure

C: tingling in (R) hand radiates from (R) elbow, intermittant, worse in AM and late afternoon



initials SB, UMT

Legend: ⊜ TP ● TeP ○ Ⓟ ✳ Infl ═ HT ≈ SP
╳ Adh ≪ Numb ⬭ rot ⁄ elev ⟝ Short ⟷ Long

skin and cosmetic conditions with laser treatments, microdermabrasion, and Botox in addition to massage and body treatments. With increasing availability, people are becoming regulars of local spas.

Spas and salons are ideal environments for wellness charting. The need for extensive charting is low, and the turnover is fast. Treatment is routine and consistent and varies little with individual needs. Clients select treatment routines from a menu, based on the general health benefits advertised. The primary role of manual therapy in a spa environment involves pampering, facilitating relaxation, cleansing, detoxifying, and toning the skin. Clients rarely consider the treatment to be a remedy for an illness or injury but rather may consider it a means of injury prevention and health maintenance.

Use of the wellness chart in spas and salons is simple and practical. Practitioners use the chart to identify health conditions that contraindicate extreme temperatures or increases in circulation. Skin allergies and sensitivities are also major concerns when gathering health history. Treatment options are checked off, and comments primarily reflect the personal preferences of the clients. Use the standard wellness chart (as shown in Figure 7-3B) or design a spa wellness chart (see Figure 7-2) to meet your individual needs.

Space is provided for multiple sessions on one chart because clients may return. In a curative health care environment, client visits typically are weekly or biweekly. In a spa environment, monthly or quarterly visits more often are the norm.

Summary

Document all massage therapy sessions. Two options for charting discussed in this chapter are

- Treatment notes
- Wellness charting

Use the wellness format for relaxation treatments and energy work—depending on the health of the client and the intent of the treatment—and in the following venues:

- Events—sporting events and health fairs
- On-site locations—offices, malls, and airports
- Spas and salons

To ensure the effectiveness of the wellness chart, vary the intake questions and treatment options according to the venue and the practitioner's treatment style. Use the wellness format for charting sessions that meet the following guidelines:

- The client is healthy and has no specific health issues.
- If the client has health issues, the specific health conditions, symptoms, and findings are not addressed in the session.
- Treatment is provided for general therapeutic benefits without the intent or expectation of altering health problems or symptoms.
- The treatment is routine.
- The client is not using the session as ongoing, curative health care treatment for a specific condition.

References

1. American Massage Therapy Association Industry Survey. *Zogby Analytics*; 2015. https://www.amtamassage.org/research/Consumer-Survey-Fact-Sheets.html. Accessed April 01, 2017.
2. https://www.towerswatson.com/en-US/Insights/IC-Types/Survey-Research-Results/2013/09/2013-2014-stayingatwork-us-executive-summary-report.
3. Chapman L.S. Meta-evaluation of worksite health promotion economic return studies: 2005 update (PDF). *Am J Health Promot*. 2005;19(6):1-12. PMID16022209 (PDF) from the original on 2010-12-07.
4. Cherkin D. Quote from slides from keynote speech at Highlighting Massage Therapy in CIM Research, Seattle; 2010.
5. Carlson R, Shield B. *Healers on Healing*. Los Angeles, CA: Tarcher Inc.; 1989.
6. Chikly B. *Silent Waves: Theory and Practice of Lymphatic Drainage Therapy*. Scottsdale, AZ: I.H.H. Publishing; 2002.
7. Werner R.A. *Massage Therapist's Guide to Pathology*. Baltimore, MD: Williams &Wilkins; 2002.
8. Mower M. The on-site massage movement: interviews with David Palmer, Russ Borner, Raymond Blaylock. *Massage Mag*. March/April 1994: 52-58.

SECTION III

Billing, Ethics, and Research

CHAPTER 8

Insurance Billing

After mastering the concepts in this chapter, the student will be able to:

- Determine personal risk of billing for each type of insurance: motor vehicle collisions, workers' compensation, and private health
- Distinguish between billing requirements for each type of insurance: motor vehicle collisions, workers' compensation, and private health
- Apply strategies for successful insurance reimbursement
- Identify a clean claim to avoid reimbursement delays
- Recognize pros and cons in individual insurance contracts
- Carry out instructions to obtain an NPI number and apply for preferred provider status with insurance companies

Zamora Hostetter was injured at work. Luckily, taxes paid by her employer provide access to a state benefit fund that pays for medical care directly related to the accident, a medical care that often includes manual therapy. This specific health care coverage is separate from her private health insurance coverage and can include payment for services that have demonstrated success in returning people to work quickly and effectively, such as manual therapy.

Billing insurance as a manual therapist usually requires a prescription from a primary health care provider (HCP). Even when a physician's prescription designates a specific quantity and frequency of care, the insurance company may further limit the number of sessions covered. For example, workers' compensation, in Zamora's case, only pays for six sessions, and they must fall within a strict date range spanning 30 days. Anything outside of the date range or more than six sessions will not be paid for by Labor and Industries (L&I) but can be provided and must be paid for by the patient.

Zamora's prescription is for 10 massage sessions, 1–2 times per week, for 10 weeks. Helena knows that, at most, she can provide 6 sessions in 30 days or Zamora will have to

cover the additional expenses. If authorized for an additional 6 sessions, Helena has as much as 60 days to provide the care. To cover those sessions, she will need to contact the referring primary care provider (PCP) and request another prescription for an additional 2 sessions. Depending on Zamora's need and Helena's ability to document the therapeutic rationale for a third set of six sessions, she may choose to request a prescription for an additional eight sessions in her report to the PCP and extend the treatments beyond the first 12 sessions, but approval for 18 sessions is uncommon. If L&I does not authorize a third set, Zamora's private health insurance may cover the care.

Helena counts off the sessions prescribed by marking the top of each treatment note with the following notation: 1/6 (10), 2/6 (10), 3/6 (10). She is tracking the number of sessions that count toward the preauthorized amount (6) and the number of sessions prescribed by the PCP (10). This way she knows when to write a report asking L&I for an additional set of preauthorized sessions and when to write a report requesting an additional prescription instructing her to provide care for Zamora's injuries. She tracks payment for the sessions to make sure the dates of service match the payment dates. Her need to document treatment sessions that show reasonable and necessary care, track prescriptions and financial information, and write reports is challenging but rewarding. She is learning a great deal working with acute traumatic injuries and feeling great satisfaction in the results she is getting. Soon Zamora's chiropractor and mother are sending her so many new patients that Helena can hire part-time office assistance and is still coming out ahead!

Introduction

Inclusion in insurance plans carries many benefits. As consumers, we have fought for the right to choose our HCPs and our preferred treatment modalities. With the rise of integrative health care, pushing the inclusion of complementary modalities into a variety of insurance plans, we see the effect of consumer demand on the insurance industry. As HCPs, we have the ability to improve the lives and health of more people by ensuring access and participating in insurance programs.

Not only does this inclusion acknowledge the positive impact of manual therapy on patients' health, but also it gives us the opportunity to promote change from inside the insurance and health care arenas. Manual therapists are hands-on, patient-centered practitioners who educate patients to ask questions and participate in their own care. All aspects of health care delivery shift, as these newly empowered patients demand the same relationship from other practitioners.

We also change the insurance industry by participating in insurance administration. For example, a group of complementary providers was hired as consultants by an insurance company to assist with integrating acupuncture, massage, and naturopathy into the company's health plans. The goal was to educate staff and medical personnel on when and why to refer for complementary services. A massage therapist spoke at length to the medical director about the company's policies for treating lymphedema. She explained that lymphedema is a chronic condition that requires long-term treatment and self-care education and should not be treated as an acute condition with a 2-week limit on care. By the next monthly meeting, the company had rewritten its policy on lymphedema treatment to include her recommendations.

Massage therapy is an industry that relies on word-of-mouth referrals. Opening our practices to health care referrals and insurance networks provides access to patients who

may never have sought our services before, including those who are not yet aware of the benefits of massage therapy, those who cannot afford to pay out of pocket for our services, and those who would not normally seek out manual therapy unless recommended by a doctor they trust. These are large populations that can substantially boost a manual therapist's practice.

Patients with acute conditions respond quickly to treatments. This patient population can offer an unparalleled learning environment. Patient files become a resource to identify effective and efficient treatments for a variety of conditions. Consistent patient outcome measures can provide effectiveness data useful for supporting referrals and influencing policy changes.

Accepting health care referrals and providing billing services can expand your patient load and your income. For example, I began offering insurance billing services in 1985. Before that, I had a modest practice in the evenings and on weekends. Immediately, I needed to hire three therapists just to help me service all the referrals. In a year and a half, my clinic had 15 manual therapists working full time to meet the demand for services. Currently, I work in a clinic with 21 massage therapists, all of whom primarily see patients referred by physicians and bill insurance.

However, insurance billing can be complicated, costly, and time-consuming, and payment is not guaranteed. Billing requires frequent communication with insurance carriers and referring HCPs, especially in this age of preauthorizations (more on these later). The communication associated with insurance billing takes time, whether on paper or online, in addition to the time therapists spend treating patients. We must be willing to maintain clear health records, remain flexible and pleasant in response to the demands of each carrier's protocols and procedures, and be persistent enough to see your way through to the end—payment in full.

To participate in many private health-insurance networks, you may be required to sign contracts and discount your fees. Think of the discounted rate as payment for marketing and the steady stream of patients sent your way. On the other hand, research shows that people are willing to pay out of pocket for our services[1] and may be willing to submit our receipts and wait for reimbursement. However, given the possibility of financial support from their insurance carriers, patients often seek out manual therapists who participate in their plans. If we do not open our practices to insurance, we risk losing patients who go in search of a manual therapist willing to provide insurance billing services.

Things to Know Before You Bill Insurance

Insurance regulations and procedures vary from plan to plan, from state to state, and even among health care professions. Just when you think you have it all figured out, preauthorization procedures are implemented, ICD-10 (International Classification of Diseases, 10th revision) codes are adopted, or a new CPT® (Current Procedural Terminology) code is introduced and a familiar one, deleted. Luckily, there are ways you can prepare for the fluctuating demands of insurance billing. This chapter provides guidelines for staying on top of the shifting information and decreasing the risks associated with accepting insurance reimbursement as payment for services.

Before you begin, ponder these questions to determine whether insurance billing services are appropriate for your practice:

1. Are peers in your area billing insurance companies? Are enough of them successful at it? Are they getting paid? Are their practices full as a result? If few of your peers are successful, you must be very creative and determined to break new ground for your profession. If many of your peers are billing insurance, you might find it difficult to compete if you choose not to participate.
2. Do you turn away people because you are unable to accommodate them? Would you like more patients? Have you ever lost a patient because you were unwilling to bill an insurance company? Have people changed their minds about scheduling with you when they found out that you do not accept insurance patients?
3. Can you afford to wait 30–60 days to get paid, which is the typical turnaround time for insurance reimbursement? Do you have adequate cash flow to meet your monthly expenses as you establish a consistent flow of insurance payments?
4. At what point will you feel motivated to offer insurance billing services? Many networks credentialing providers fill up quickly and close their doors to new providers within a year of offering massage therapy coverage in the plans. Will the insurance networks be closed when you are finally ready to join? Or will you retire before insurance billing is standard for your profession in your area?

FROM THE LITERATURE

Provide Access to Manual Therapy

Colodia Owens, author of *Managed Care Organizations: Practical Implications for Medical Practices and Other Providers*, asks, "Is health care a right, a privilege, or a rationed commodity?"[2] I believe that health care is a right, and with a little tenacity and organizational skill, I can provide health care to my patients under their insurance plans. My participation in the insurance industry is a choice, and it makes me feel glad every time I look into a patient's grateful eyes—the police officer with a broken neck, the poet with lymphedema from a double mastectomy, and the professor with a closed-head injury. Together, we nod knowingly. This is care they don't get anywhere else.

Whether or not you provide billing services, use the guidelines provided in this chapter together with information you gather that is specific to your state or region and to your scope of practice and be thoroughly informed, both for your sake and the sake of your patients. If you choose not to provide billing services for your patients, and instead provide a receipt with instructions on how patients can seek insurance reimbursement on their own, educate yourself thoroughly to avoid burdening your patients with unnecessary risk. Collecting the information necessary to be fully informed requires some effort on your behalf, including making phone calls to peers and governing bodies, such as the Department of Health or Department of Education, insurance representatives, and attorneys. You will also need to read current materials specific to your location and practice, including professional journals, insurance provider newsletters, and billing texts. Moreover, attend local workshops and seminars. Because of regional and professional differences in insurance billing and because licensing laws continue to change in many areas, it is critical to stay abreast of trends in

insurance reimbursement that can affect your practice. Playing the role of "ostrich in the sand" is not a viable option if an insurance review determines that you have received payment for services not within your scope of practice or that the fees charged were in excess of your usual fees. You can be forced to reimburse money that was paid to you, and in many instances, violations can be retroactive for several years. Follow the strategies suggested for managing insurance reimbursement and fill in the blanks with information specific to local laws and professional regulations. Carefully read Chapter 9, Ethics and ensure that your fee schedules are legal and ethical. Become well informed and prepared to meet the demands of insurance billing. Research the following before providing billing services:

- If you are a licensed HCP, what services are within your legal scope of practice? Can you bill directly for your services? Do you need a prescription from a referring HCP, or do you have diagnostic scope? Which type of HCP has primary care status and can refer patients for massage therapy treatments?
- If you are not a licensed HCP, do regulations exist that permit you to provide health care services under the license or supervision of an HCP with primary care status? Can you bill directly or must the supervising HCP bill for you? Do you need direct supervision or will a prescribed treatment plan and a referral suffice?
- Which types of insurance (for example, private health insurance, worker's compensation, or personal injury protection [PIP] coverage) will reimburse for massage therapy services in your state?

Once you determine that you are eligible to receive reimbursement for massage therapy services from insurance companies, confirm the billing and reimbursement procedures for each patient. For example, Blue Cross, a private health insurance company, has many plans available for consumers to purchase, and each plan has its own requirements for billing and reimbursement. Obtain the answers to the following questions before providing billing services to a new patient, answers you can require your patients to provide, or you can contact the insurance company directly:

- Is the patient's condition, such as muscle or joint pain, fibromyalgia, or cancer, covered under his or her insurance plan? Provide the insurance representative with the corresponding diagnostic code using ICD-10 codes. (See online, Appendix E for a condensed list of ICD-10 codes. For a complete listing, go online to http://www.cdc.gov/nchs/icd/icd10.htm.)
- Are physical medicine and rehabilitation the covered benefits for the patient's condition (the category of service that massage and other manual therapies fall under in the CPT® code manual)?
- Who can provide the massage or manual therapy treatment (a massage therapist or physical therapists, nurses, chiropractors, etc.)?
- Which therapeutic procedures or modalities are reimbursable when the professional therapist (i.e., licensed massage therapist) provides the service (i.e., patient intake/evaluation, massage, manual therapy techniques, therapeutic exercise, neuromuscular reeducation, or hot/cold packs)? Provide the CPT® codes that correspond with the services being offered.
- What are the restrictions of each CPT® code? These include services that cannot be provided on the same date of service, such as 97124 and 97140, time limits on the duration of the treatment session, or the maximum reimbursement rate for the service.
- How many visits are allowed? Are they combined with other provider types? How many have been used this calendar year?

- How much of their deductible is satisfied and what is their co-pay amount (collect the co-pay amount at each session)?

If you choose to provide services without being a credentialed provider within the network (required with all workers' compensation, most private health insurance, and sometimes PIP if the car insurance policy is linked to a managed care contract), there is another set of questions to ask either your patient or the insurance company directly:

- Is there a separate deductible for out-of-network providers? How much of that is satisfied to date?
- What is the coinsurance amount (a percentage of your fee, different than a set co-pay amount) due at each session?

In this chapter, forms are provided for identifying and recording information on your patients according to each individual plan. The accompanying guidelines assist you with communication and organizational skills to make the insurance billing process flow smoothly and to decrease the risks involved.

To get started, familiarize yourself with the following terms and resources:

- Physical Medicine and Rehabilitative Services: These are headings in insurance policy manuals and CPT® codebooks that contain the services provided by most manual therapists. Review your own insurance policy booklet, sometimes called the Certificate of Coverage, and read the Schedule of Benefits. Under Physical Medicine (or Rehabilitative Services), read the description of covered services and excluded services. The list will include those who can provide the services, services that are allowed or excluded, whether or not a prescription is required, and a definition of medical necessity. For example:

  Rehabilitation services are covered … to restore or improve functional abilities following illness, injury, or surgery. … All services must be prescribed and provided by a rehabilitation team … that may include … medical, nursing, physical therapy, occupational therapy, massage therapy and speech therapy providers. … Such services are provided only when significant, measurable improvement to the Member's condition can be expected within a 60-day period.

  Excluded: … therapy for degenerative or static conditions when the expected outcome is primarily to maintain the level of functioning … recreational, life enhancing, relaxation, or palliative therapy.[3]

- ICD-10 codes: The initials refer to the International Classification of Diseases, 10th Revision, which is a system of classifying diseases using specific diagnoses code numbers to describe a patient's health care condition that the United States adopted in 2015. ICD-10 codes are updated periodically and published by the World Health Organization (WHO). They are recommended for use in all clinical settings and are required when reporting diagnoses and diseases to the U.S. Public Health Service and the Centers for Medicare and Medicaid Services (CMS). Current ICD-10 codebooks are no longer available in print and are available online via the Centers for Disease Control and Prevention (CDC) Web site. New, revised, and discontinued codes can be accessed at no charge at https://www.cdc.gov/nchs/icd/icd10cm.htm.
- CPT® codes: These are standardized numerical codes and descriptions of clinical procedures developed and trademarked by the American Medical Association (AMA)

with the intent and spirit to accurately describe clinical procedures in a non–provider-specific way so that personnel in any specialty or discipline may use them.[4] CPT® codes are updated annually and published by the AMA and are available online. A patient or a consumer may perform CPT® code searches and obtain information about Medicare's relative value payment associated with the codes for free. There is a limit of five searches per day at no charge. You are required to create an account to access the code search function https://login.ama-assn.org/account/login.

- CCI or NCCI bundling: Correct Coding Initiatives (CCI) or National Correct Coding Initiatives (NCCI) are pairs of CPT® codes that cannot be reimbursed when paired together on the same date of service. They must be bundled and submitted as a single code only. For example, CMS does not allow a practitioner to bill for manual therapy—97140—and massage therapy—97124—on the same date of service. This is the only pairing to date that directly affects massage therapists. Many private health insurers follow CMS guidelines, and even though you may not bill Medicare, you may still be bound by Medicare policies. To access updates on pairings, access the CMS Web site at http://www.cms.gov/NationalCorrectCodInitEd/. This article explains how to use the NCCI coding tools: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf.

Evaluation CPT codes have recently changed, as mentioned previously. Before billing using the new codes, it is important to know the scope of practice in your state and whether you can bill using those codes. Owing to scope-of-practice issues, there has always been a great deal of controversy around massage therapists using evaluation codes. Previously, the most commonly used evaluation codes included a diagnosis, which automatically excludes any HCP without diagnostic scope. New codes are written with physical therapists and occupational therapists in mind and even carry those titles. In fact, the codes defined below specifically say physical therapy evaluation. However, CPT codes are not restrictive to a profession but rather define the type of care and can be used by any other discipline that has the scope of practice to perform these procedures.

In Washington State, for example, the rules for massage therapists include a definition of evaluation (WAC 246-830-005). Become familiar with the definitions below and the scope of practice in your state, before billing for these services. Each insurance company outlines which codes are reimbursable; even if it is in your scope of practice, some insurance companies may not reimburse you for them.

The new evaluation codes distinguish between low (97161), medium (96162), and high (97163) levels of complexity for initial evaluations, with one reevaluation code (97164).

Low complexity is defined by the following:

- Health history: no personal/life issues or comorbidities that affect the plan of care for the current condition
- Examination: 20-minute minimum evaluation using one or two standardized tests or measures from any of the following: body structures and systems, activity limitations, and/or restrictions in activities
- Clinical presentation: stable or uncomplicated characteristics
- Decision-making: low complexity using standardized patient assessment tools and/or measureable assessment of functional outcomes

Moderate complexity involves one or two personal/life issues or comorbidities that affect the plan of care and requires an expanded evaluation (30 minutes or more) to review of medical records and implement assessment tests and measures. Three or more tests and measures must be performed, clinical decision-making that requires more advanced skill and interaction with the health care team and/or family.

High complexity requires a minimum 45-minute evaluation, three or more comorbidities or personal/life issues, and four or more tests or measures must be performed. The patient must present with unstable and unpredictable characteristics, and clinical reasoning is of high analytic complexity, with consideration of multiple treatment options, and significant moderation of tasks or assistance.

It is important that the new codes are applied consistently, both across professions and from therapist to therapist. The level of severity of an injury, the age of the patient, prior health history, level of function, cognitive status, motivation level, and the patient's home situation all influence a patient's ability to heal. Here are four components that therapists are directed to use to select the appropriate evaluation code:

1. Patient history and comorbidities
2. Examination and the use of standardized tests and measures
3. Clinical presentation
4. Clinical decision-making[5]

Generally, patients of massage therapists fall into the low-complexity category, with a few patients reaching the moderate level. For example, I have a patient with Parkinson disease who came to me for help after a knee replacement. Parkinson disease affects his eyesight, balance, speech, and cognition. His muscles are getting increasingly stiffer, with his toes curling under, causing him to fall often. These comorbidities complicate his ability to have a speedy, successful recovery. Luckily, he has a supportive family and a will to improve his condition. He can care for himself, and his progress is degenerative but predictable. This would be considered a moderate-complexity evaluation. I perform ROM (range of motion)tests; administer pain, stress, and activity tools; and set functional goals regularly.

The only patients I can think of who classify as a level three are my amyotrophic lateral sclerosis (ALS) patients when they reach end-stage. They require wheelchair transfers, assistance getting dressed and undressed, and have difficulty communicating, breathing, and swallowing. I need regular communication and coordination with the family and health care team to treat them safely and effectively.

Types of Insurance Coverage

Three common types of insurance coverage are personal injury coverage, workers' compensation, and private health insurance.

Manual therapists, licensed or unlicensed, may be able to have their bills reimbursed through a personal injury claim. When injuries result from a collision involving a motor vehicle (car crash, a pedestrian or a bicycle is hit by a car) and the person injured or the at-fault party has PIP through their car insurance, the insurance should cover medical care. These treatments generally include services intended to help the patient return to preinjury status or to reach maximum medical improvement. Manual therapy is usually included as long as the therapy is medically necessary, is prescribed by a primary HCP, and is performed

by a licensed HCP (or is under his or her supervision). Licensed providers are typically reimbursed in a timely fashion through the patient's PIP clause within the car insurance policy, whereas nonlicensed providers are often not reimbursed until the end of settlement.

Many workers' compensation plans cover massage therapy services because in-house statistics support it as an inexpensive and effective way to return patients to work quickly. These state and federal plans provide for massage therapy treatments for most on-the-job injuries and lead the way for inclusion in other health plans.[5] The number of sessions is limited, and providers must go through a credentialing process before seeking reimbursement.

Private health insurance, on the other hand, tightly defines the treatments and modalities that are reimbursable and the conditions under which they are covered. Insurance plans that cover massage therapy will often reimburse the treatment only when it is provided by physical therapists, nurses, or chiropractors. Few cover massage therapy provided by licensed massage therapists or certified bodyworkers. Increasingly, however, consumers are demanding that insurance carriers include integrative health care options in their plans, including massage therapy, acupuncture, naturopathy, and others. Currently, 35 states, including Florida, Illinois, Massachusetts, and Wisconsin, have what is called an any willing provider (AWP) statute that allows willing providers to cover services for a predetermined fee that will be accepted by the health carrier. Be aware that the laws are not consistent from state to state. Many use this clause to include pharmacies and may still limit the number or type of provider. In addition, states such as Washington benefit from a nondiscrimination statute indicating that insurers must contract with every category of HCP. In this scenario, HCPs must be licensed or certified by the state's department of health and contracted by the insurance carrier, the patient's condition must be within the HCP's scope of practice to treat, and treatment must be within the provisions of the patient's insurance policy.

Manual therapists in some states can bill all three types of coverage successfully. However, in other states, success may be obtained in only one or two of the three. Do your homework before providing the service.

PERSONAL INJURY INSURANCE*

Personal injury insurance is bundled into insurance policies such as car insurance, homeowner's insurance, and commercial building insurance. Commonly, policyholders purchase medical coverage within these plans for personal injury, medical payments (MedPay), and liability coverage (which includes bodily injury and property damage).

The most common type of claim for personal injury insurance is for injuries sustained in a motor vehicle collision (MVC). Each year, three to five million MVCs are reported to the police and to hospitals in the United States and countless more go unreported.[6] Nearly two and a half million people are killed, disabled, or injured as a result of these MVCs annually. Because of these staggering numbers, therapists in practice will frequently find themselves billing automobile insurance carriers.

Manual therapists need to be aware of five types of insurance coverage when treating patients involved in MVCs:

- PIP
- MedPay

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- Secondary PIP or secondary insurance
- Third-party coverage or liability insurance
- Uninsured motorist (UM) protection

Personal Injury Protection

PIP is one component of automobile insurance coverage that can be purchased as part of any auto policy. Some states (about 16) require drivers to purchase PIP. In other states, it is optional. In Washington State and Texas, for example, insurers are required to offer PIP to their policyholders, who have the right to refuse such coverage by signing a formal written "waiver" recognizing their understanding of the coverage and their decision to reject it. Benefits may include payment of medical and hospital fees, recovery of lost wages and loss of services (such as household help), and payment for funeral services. Payment of these benefits does not depend on any determination of who was at fault.

Various levels of PIP coverage can be purchased, and every company offers different options within those levels from $5,000 to $250,000. A standard time provision on PIP coverage varies from 1 to 3 years. Therefore, it is important to know the provisions specific to each patient's plan before agreeing to bill directly to the insurance carrier. This will help ensure that the time limit has not expired or that coverage has not been exhausted by bills from other health care practitioners.

From a reimbursement standpoint, PIP is the most attractive type of coverage. Therapists do not have to wait for fault to be determined, nor do they have to deal with health insurance policies that may not cover their treatment modalities. The primary requirement is that your documentation prove that your care is reasonable and necessary and that the treatment is for injuries sustained in the collision. Moreover, a referring HCP must have prescribed the treatment as medically necessary.

Medical Payments

MedPay coverage is also a provision that can be purchased under the auto insurance policy. Again, the amount of coverage differs from state to state and from insurer to insurer. If there is no PIP coverage, MedPay may be available to cover massage therapy services. MedPay is generally available for a lower dollar amount than PIP and covers medical expenses only. As with PIP, payment does not depend on determining who was at fault.

Secondary Personal Injury Protection or Secondary Insurance

One or more PIP or MedPay policies may cover your patient for the same collision. For example, when Darnel was a passenger in his nephew's car, the nephew's PIP paid for Darnel's medical expenses as the primary insurer, even though Darnel had car insurance. If the nephew's PIP was exhausted, Darnel's PIP insurance coverage could kick in as the secondary PIP insurer if additional medical services were needed. If Darnel did not have PIP or MedPay and the nephew's PIP had exhausted, Darnel's health insurance would become the secondary insurer. If both the nephew's and Darnell's PIP were exhausted, Darnell's health insurance would also step in. Any time a patient's health insurance is involved, there is the risk of manual therapy not being a covered benefit. If this is the case, it becomes an end-of-settlement situation (see below).

Third-Party Coverage or Liability Insurance

Third-party coverage refers to the liability insurance coverage of the at-fault party. The driver of the truck that rear-ended Darnel is the at-fault party, and his insurance plan is the third-party or liability insurer. Billing the third-party insurance company is unproductive because the company is not required to pay bills until the injured party making the claim is ready to settle the entire claim at one time.

End-of-settlement cases are those in which the patient was not at fault and the patient's PIP or MedPay coverage (or secondary insurance) is insufficient or nonexistent and the provider of health services, such as a manual therapist, must wait until the claim against the at-fault party settles or a judge or jury issues a verdict before receiving payment for services. End-of-settlement cases can be risky. The patient may not be able to prove that he was not at fault. If Darnel, for example, had an attorney who was convinced that fault on the part of the truck driver could be established, the risk would be lessened. However, can you as a therapist in practice afford to wait until the case settles before getting paid? In many cases, months or even years will pass before a settlement is reached, depending on the statute of limitations and whether the case ever goes to trial. If the patient and the lawyer are willing to sign a contract guaranteeing your payment once the settlement ends, your risk will be reduced. A health care lien, filed in accordance with the requirements of your state, can lower the risk even further.

The positive side of an end-of-settlement case is that it becomes a savings account gaining simple interest monthly. Interest can be applied within the legal limit for health care services. For example, in the state of Washington, interest begins to accrue 45 days after no payment is made if you notify the patient at the beginning of treatment that interest will be charged (assuming payment is not made at the time services are provided). Some states also regulate how much time must pass before interest can accrue, which may be 45, 60, or 90 days. There may also be a requirement to inform the patient about interest charges before the clock starts ticking. If you ensure adequate cash flow by limiting the number of end-of-settlement cases you carry at a time and if you take precautions to reduce your risk, the occasional end-of-settlement case can enhance your cash flow (see Chapter 3, Communication with the Legal Team, for information on reducing your risk by enhancing your relationship with the legal team).

In the event that the patient's insurance carrier pays for expenses up front, it will rely on the subrogation provisions in the patient's insurance contract with the insurers. Under subrogation, the insurer will seek reimbursement of its health care payments from the injured party's third-party settlement. Subrogation is a complicated legal principle that has many exceptions and differences in implementation from state to state. Generally, subrogation means that a patient cannot have the same bill paid twice. This can happen when the PIP or health insurer pays a bill, and, during the third-party case, the patient has his or her attorney use the bill and chart notes to demonstrate evidence of injury and economic loss. When the bill is used as evidence of damages and a settlement is reached involving that bill, it has been paid twice and the patient's insurer will assert a claim for reimbursement.

Uninsured Motorists

UM coverage protects the policyholder against MVC injuries inflicted by someone who does not have an active insurance policy or who flees the scene and remains unidentified. This coverage is also activated when the person who causes the collision has insurance, but the injured person does not.

WORKERS' COMPENSATION

Workers' compensation is insurance that employers are mandated to purchase for all employees. These plans furnish medical and disability benefits for illnesses, injuries, disabilities, and death that result from job-related conditions and activities.

The primary intent of this coverage is to return the employee to full-duty work quickly and without recurrence of injury. Benefits vary from state to state. Often, limits apply on the services that are reimbursable, on who may perform those services, and on how many sessions are available. For example, fees allowed must be accepted as payment in full, and health providers must agree to contracted provisions. Request a copy of the provider regulations for your profession and an application for a provider number, if applicable. Read the regulations thoroughly before determining whether you want to provide this service to your patients (see online, Appendix F for contact information).

Each state has an insurance plan available to employees through its Department of Labor and Industries or workers' compensation program. Employers pay fees according to job description, and funds are collected quarterly. Employers have the option of using the insurance provided by the state or, if their business is large enough, may choose to be self-insured. These self-insured plans must meet or exceed the coverage mandated by state law. For example, the US government is self-insured. Rather than managing different plans that cover employees in every state, the federal government uses its own plan that meets or exceeds the requirements in each state. All federal claims, regardless of the state in which the employee works, are submitted to the same workers' compensation insurance carrier.

PRIVATE HEALTH INSURANCE

Private health insurance provides payment of benefits for covered illness and injury. Many types of health care reimbursement plans exist, with an array of companies to supply them, including the following:

- Managed care plans
- Indemnity plans or fee-for-service plans
- Major medical
- Medicare and Medicaid

The most widespread type of health insurance plan today is managed care. Traditionally, people would go to their own doctor whenever they felt it was necessary. The doctor would do whatever he or she deemed necessary for the patient's health and would submit a bill to the insurance company for that visit. The insurance company would pay the doctor for the services provided. This is known as an indemnity plan or a fee-for-service type of health care. Because of an increase in accessibility of health care, the unrestricted use of reimbursement, and rising health care costs, insurance companies were driven to search for ways of managing health care costs, giving rise to today's managed care plans.

Managed care was created to limit the following:

- Coverage of services
- Suppliers of those services
- Fees for those services

Major medical insurance covers the expense of major illness and injury. There are usually high benefit maximums and high deductibles, and the insurance company reimburses a percentage of the costs after the deductible.

Medicare and Medicaid provide public assistance to the aged and the financially challenged, respectively. These types of health insurance plans place restrictions on the techniques and modalities that are reimbursable.

Managed Care Plans

Managed care organizations manage costs by contracting with selected groups of providers who agree to receive predetermined rates. An administrator manages the patient's access to health care, assesses the patient's case from a financial and clinical perspective, develops a plan of care in conjunction with the referring HCP and other HCPs, determines medical necessity, and evaluates the quality of care provided. Managed care integrates the financing and delivery of health care services to covered individuals. Significant financial incentives are offered for members to use providers within the "network" and procedures associated with the plan.

Health Maintenance Organizations

Health maintenance organizations (HMOs) are a type of managed care organization. HMOs combine insurance reimbursement with the delivery of health care services and provide specified medical services to defined groups of individuals for a stated period of time at a fixed price.

HMOs vary in structure and in reimbursement methods. Some vary in their contracts with providers. For example, a group model contracts with a group of providers. An independent practice arrangement (IPA) contracts with providers in private practice. The point of service model allows the insured to use the contracted providers or receive services from outside the network. There are financial incentives to stay within the network of providers, however.

Reimbursement arrangements in HMOs include the following:

- Discounted fees for services
- Capped fees for services
- Bundling fees for all services provided
- Capitation

A discounted fee arrangement is a managed care approach in which the provider contracts with the insurance carrier to offer services to the insured at a discount. This is also known as an affinity plan or affinity network. The patient pays the provider the discounted fee directly, and the provider accepts this fee as payment in full.

With a capped fee, the provider contracts with the insurance carrier for services at a reduced cost. The insurance carrier reimburses the provider for services at the capped rate—payment comes from the insurer—and the provider accepts this fee as payment in full. Bundling, or a global fee schedule, lumps all services provided into one fee. For example, Helena, Zamora's manual therapist, provides several services, including structural integration, hydrotherapy, and polarity therapy. She bills each one at a different rate. With this reimbursement arrangement, all her services are lumped into one CPT® code—97124—and billed at the same rate.

Capitation is a fixed monthly payment made to a managed care insurer for contracted services during a specified time period, regardless of how many times the member uses the services. Capitation is nearly impossible to be applied to massage therapy practices because of the time required for delivering the service and the physical inability of the practitioner to provide more than a predetermined number of sessions per day.

Preferred Provider Organizations

Preferred provider organizations (PPOs) are similar to HMOs, except that they primarily contract with independent providers and they share similarities with the traditional fee-for-service health plans. PPOs were developed as a bridge between managed care plans and indemnity plans as a response to concerns that services provided by HMOs could become inflexible, that patients' choice of providers could be eliminated, and that accelerating costs could make indemnity plans too expensive for employers and policyholders.

Becoming a Preferred Provider in a Managed Care System

Credentialing

Some insurance plans have a credentialing process for contracting with preferred providers. Other insurance carriers buy contracts from an insurance network. Networks credential providers and sell their contracts to insurance carriers for a user fee. The credentialing process varies among carriers and networks, but it generally consists of the following:

- Review of company standards, such as years in the profession and accessibility
- Completion of an application and acceptance of professional references
- Signed contract showing agreement to company policies and provider services, including a hold harmless clause in the event that the carrier becomes insolvent, to prevent HCPs, including manual therapists, from seeking payment from the patient
- Proof of licensure, certification, registration, or all three
- Proof of business license
- Proof of liability insurance
- Proof of education certificate, continuing education hours, and current CPR training
- Proof of professional affiliations with organizations that enforce a code of ethics
- Background check for complaints and disciplinary actions

Plans often hire consultants from the profession to assist in developing credentialing criteria and procedures, as more plans integrate massage therapy. However, once the criteria are in place, credentialing and peer reviewing are usually done by someone familiar with several professions, not just the one being reviewed. For example, a nurse might be hired to conduct a peer review for massage therapists, physical therapists, and occupational therapists.

Site inspections and reviews of patient records are common components of credentialing. Many insurance carriers will not credential practitioners who work at home, who do not provide handicap accessibility, or who do not maintain adequate patient records.

Specific continuing education courses in, for example, documentation and billing may be required as part of the credentialing process. Similarly, a quality improvement program may be mandatory for recredentialing on an annual basis. The manual therapist also agrees to comply with utilization management programs, which randomly audit practitioners to evaluate the effectiveness, appropriateness, and quality of services provided.

Contracts

Contracts vary among plans and among providers. Read all contracts carefully because they are legally binding. An article in the *Journal*, a publication of the American Massage Therapy Association Washington Chapter, mentions paying close attention to the following sections of a contract:[7]

- Fee schedules
- Patient access
- Contract termination
- Records and documentation

By contracting with an insurance carrier, you agree to receive a discounted rate as payment in full. Marketing can be expensive and time-consuming for small businesses. Many manual therapists are unprepared for the demands of self-employment and the responsibilities of marketing, which are in addition to providing services. Becoming a preferred provider may be a great boon to your business. Before agreeing to any discount, however, calculate your expenses, including additional office expenses for handling billing services, and determine your bottom line for each patient visit. Make sure the discount supports your business and does not become an unnecessary burden.

Some contracts may require you to keep a specified percentage of your practice open to their insureds. This can limit your ability to hold appointments open for cash patients. Other contracts require you to provide the agreed-upon discount to patients paying cash for wellness care if they are members of the plan, even though you are not billing the carrier for treatments. Some plans extend the discounted rate as payment in full to insureds involved in MVCs or on-the-job injuries, even if the worker's compensation or personal injury insurance reimburses at a higher rate. Read the patient access provision carefully and sign a contract only when you are willing to abide by it.

Consider how many days it takes to terminate a contract. Plans may require written notice from 30 to 120 days before the contract can be terminated without cause. If a plan reserves the right to revise the pay scale at any time, you may be bound to a rate that is unacceptable to you for months before you can terminate your contract. Most plans increase the fee schedule over time, but if the rates are reduced, it could cause you financial hardship. When the Affordable Care Act was implemented, many insurance companies reduced reimbursement rates out of anticipation of increased use of complementary services. When this increase did not occur, fees were not returned to previous rates. This caused a hardship on many massage therapy practices that have a high percentage of physician referrals for patients seeking treatment.

Contracts will specify reasons for immediate termination. Read these carefully. Something as simple as not providing copies of patient records within 3 days can breach the contract and result in immediate termination. You should always learn what is expected of you and determine whether you are able to comply before signing any contract.

Inadequate documentation, as defined by some contracts, can allow the plan to refuse payment to you for your services. Find out the plan's definition of adequate documentation. Follow the guidelines presented in this book, and you will most likely meet or exceed the requirements.

Many contracts stipulate that copies of patient files must be provided free of charge on request, within a set number of days of receiving the request. Contracting with an insurance plan may require computer access, although many still accept hard copy files via fax. Most communication can be done online now or via telephone. Make sure you comply with HIPAA (Health Insurance Portability and Accountability Act) regulations on your end when sending files electronically. (See Chapter 5, Documentation: Intake Forms, for information in HIPAA compliance.)

Contracts may be amended if both parties agree to the changes. If the original contract is unworkable for your practice, but several of your patients are policyholders, request changes to the contract. The insurance carrier may be willing to negotiate

with you. Your chances of successful negotiation become greater when several practitioners approach the company in an organized and professional manner. Use your membership affiliations to join forces, pay for counsel, and shape your relationships with carriers. Take care not to violate federal antitrust laws prohibiting providers from joining together to boycott a contract or to set fees. Hire legal counsel to ensure that all laws are followed. The American Massage Therapy Association—Washington chapter (AMTA-WA) hired counsel to review several insurance provider contracts and to advise members of changes to request as a group. The reviews were published in the *Journal*, which benefited hundreds of massage therapists who were considering the contract. A group of volunteers requested meetings with some of the insurance plans, and negotiations were fruitful. To this day, the WA chapter has a good reputation with insurance carriers and continues to meet with representatives to shape the relationship between practitioners and carriers. Recently, volunteers met with the outside organizations that provide preauthorization services for many health carriers. The initial requirements were cumbersome; changes were implemented as a result.

Approach the carriers from a position of cooperation and education rather than animosity. You may feel insulted when they offer to pay you as little as half of your customary fee, but an adversarial approach will not win you respect or give you an edge in negotiations. Every type of HCP struggles with contracts, fee schedules, and reimbursement arrangements, and all try to negotiate a living wage. Be professional, educate the carriers about your profession, and try to understand the insurance company's position, as well as your own, during the negotiations.

TALES FROM EXPERIENCE

Every Provider Reduces Fees to Participate in Provider Lists

I had arthroscopic knee surgery recently. My jaw dropped when I received the explanation of benefits (EOB) statement from my insurance company. The surgeon's fee exceeded $3,000, but that wasn't the shocking news. My insurance company paid him $888 as payment in full! And I was upset about reducing my fees by 25–50%, depending on the insurance contract. My surgeon's fees had been reduced by more than 65%.

Guidelines for Insurance Documentation

PATIENT INFORMATION

Documentation for insurance personnel carries the same requirements as other forms of patient documentation. Everyone is interested in information that accurately reflects the patient's health and the treatment provided. The only thing to consider is that care can be discontinued and payment, reversed or denied based on the documentation.[8] Adequate documentation includes the following:

- Intake forms
- Prescription
- Treatment notes
- Progress reports

Recordkeeping must meet two goals for insurance reimbursement. First, you must justify care on that day. Second, you must justify the overall treatment plan.[8] To justify care on the day of service, document the following:

- Symptoms consistent with the condition covered by the insurance plan at the time treatment was provided
- Alteration of the patient's daily routine (at work, home, or recreational pursuits) because of the condition
- Positive objective findings within your scope of practice, including spasms, trigger points, postural deviations, and such

To justify the treatment, demonstrate that the techniques and modalities you use are positively affecting the patient's condition and improving the patient's quality of life:

- Present a treatment plan that identifies the goals of the sessions and shows how you and the patient will work to accomplish the goals.
- Perform evaluations to assess the effectiveness and efficiency of the treatment plan. Moreover, identify the patient's progress toward accomplishing the stated goals using measurable changes in the patient's ability to perform daily activities (functional outcomes) and measurable changes in subjective and objective data.
- Adjust the treatment plan to respond to the individual needs of the patient, as determined by the progress evaluations and the goals accomplished.

Most HCPs refer patients with musculoskeletal conditions to manual therapists; however, we are starting to see a rise in prescriptions requesting treatment for anxiety. To justify care for anxiety, use the stress scale found in the Hands Heal EHR (electronic health record) (see Figure 8-1). To justify your treatment, show progress pre- and postsession and over time. Moreover, demonstrate that improvement in physical measures (pain, sleep, activities) influences the overall sense of well-being.

Follow the guidelines presented in this book to help prepare yourself to produce documentation that meets insurance requirements for reimbursement.

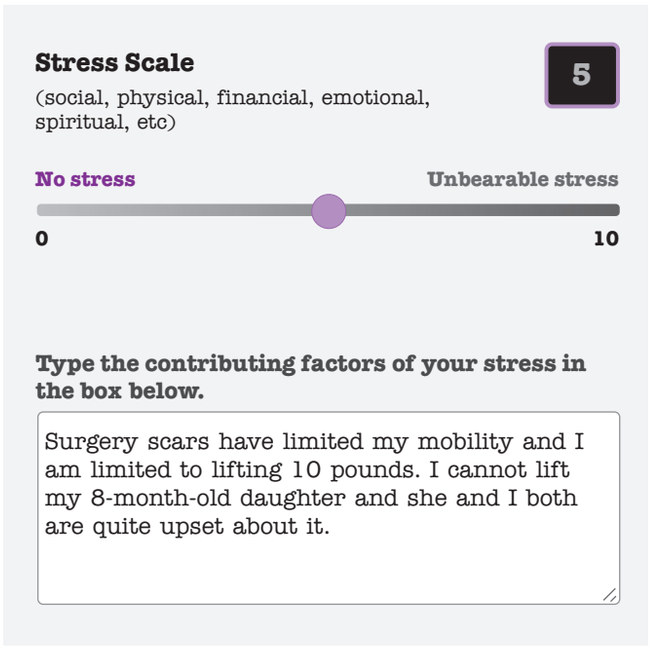
INSURANCE INFORMATION

Make sure you have all the information necessary for insurance reimbursement before filing claims. The primary cause of payment delays is lack of information or inaccurate information on the billing form.[9] Because each insurer and each insurance plan have their own requirements for billing and reimbursement, you may need to confirm the billing and reimbursement information for each new patient and for each new occurrence or condition.

Two forms will help you identify the information necessary for insurance billing and reimbursement: the billing information form and the insurance verification form.

The first, the billing information form, is an intake form that must accompany the intake forms presented in Chapter 5, Documentation: Intake Forms, when providing billing services (see online, Appendix B for blank forms). This form provides contact information for the insurance company and states your billing and office policies. Three billing information forms are provided here, one for each type of insurance. Information required to bill private health insurance—billing information—varies widely from workers' compensation to MVC. It is best to have a separate form for each,

FIGURE 8-1. Presession Measurement Scale–Stress



both for ease of use by the patient and for ease of billing. Create separate file folders for easy retrieval when needed, which are labeled accordingly: Billing Information: Motor Vehicle Collision, Billing Information: Workers' Compensation, Billing Information: Private Health.

The second, the insurance verification form and worksheet, has two parts: the massage therapist (MT) worksheet and the patient worksheet. The insurance verification: massage therapist (MT) worksheet is completed by the practitioner; the insurance verification: patient worksheet is completed by the patient (see online, Appendix B for blank forms). The practitioner worksheet is used to verify the insurance coverage for specific services or CPT® codes and identifies limitations or restrictions on the benefits for those services. The patient worksheet gathers financial information regarding benefits, such as a co-pay or deductible. Verify services in advance of billing to ensure you are providing services that are covered by the patient's plan and payment won't be denied. Ask the patients to verify benefits in advance to ensure that they are aware of their financial responsibility so that they may budget accordingly.

Any time information is verified over the phone, record the date, time, and name of the person you are speaking with directly on the insurance verification form and include notes on the conversation. Use a phone log for noting additional phone calls not pertaining to the insurance verification form. All conversations pertaining to patient information should be documented. It is easier to confirm information with the insurance carrier should something go awry when you can provide specific information about the date and time and the name of the person with whom you spoke.

Billing Information Form

The billing information form (see Figures 8-2, 8-3, 8-4, insurance information forms) collects information used to complete the top half of the CMS 1500—the standard billing

form for insurance companies (see Figure 8-9)—and states your billing and office policies. Information on this form includes the following:

- Personal identification and contact information for the patient, the insured, and the referring or attending HCP. Attorney information is included on the MVC billing form only.
- Insurance identification and contact information—primary and secondary—and the name and phone number for the insurance adjuster.
- Billing and office policies.
- Statement of financial responsibility.
- Assignment of benefits.
- Release of medical records.

Three billing information forms are provided to ensure adequate data is obtain for each different scenario: MVC, and workers' compensation, and private health (see Figures 8-2, 8-3, 8-4).

Personal Identification and Contact Information

All pertinent contact information for the patient, the insured, the insurance company and adjuster, the attorney, and the referring or attending HCP is included on the billing information form. Some information recorded on the billing intake form may duplicate data on

FIGURE 8-2. Billing Information: Private Health

Provider **BILLING INFORMATION-PRIVATE HEALTH**

Patient Information

Name_____ Date_____
Address_____ City_____ State_____ Zip_____
Home/cell #_____ Work #_____ email_____
Date of birth_____ SS#_____ Date of injury_____
☐Female ☐Male ☐Single ☐Partnered/Married ☐Other
Referring Health Care Provider_____ phone#_____
Address_____ City_____ State_____ Zip_____

Insurance Information

Primary Insurance Co. Name_____ phone#_____
Ins Co Address_____ City_____ State_____ Zip_____
Ins ID (alpha prefix) #_____ Group/Plan #_____
Name of Insured_____ Date of birth_____ SS#_____
Relationship to insured ☐Self ☐Spouse/Partner ☐Child
Insured's gender ☐Female ☐Male
Insured's employer or school_____
Do you have secondary coverage with another insurance company? ☐Yes ☐No
If yes, please complete the following section:
Secondary Ins Co Name_____ phone#_____
Ins Co Address_____ City_____ State_____ Zip_____
Ins ID (alpha prefix) #_____ Group/Plan #_____
Name of Insured_____ Date of birth_____ SS#_____
Relationship to insured ☐Self ☐Spouse/Partner ☐Child
Insured's gender ☐Female ☐Male
Insured's employer or school_____

FIGURE 8-3. Billing Information: Worker's Comp

Patient Information

Name_____ Date_____
Address_____ City_____ State_____ Zip_____
Home/cell #_____ Work #_____ email_____
Date of birth_____ SS#_____ Date of injury_____
☐Female ☐Male ☐Single ☐Partnered/Married ☐Other
Attending Health Care Provider_____ phone#_____
Address_____ City_____ State_____ Zip_____
Employer_____ phone#_____

Insurance Information

Insurance Co. Name_____
Ins Co Address_____ City_____ State_____ Zip_____
Claim #_____ Adjuster's name_____ phone #_____
Have you received any massage therapy for this injury? ☐ Yes ☐ No # of sesions_____
Number of visits authorized_____ Number of visits remaining_____
Date claim opened_____ Dates of coverage_____

FIGURE 8-4. Billing Information: Motor Vehicle Collision

☐Auto Collision - In what State:_____
☐Job-related Auto Collision – Employer:_____
Was the collision your fault? ☐ Yes ☐ No

Patient Information

Name_____ Date_____
Address_____ City_____ State_____ Zip_____
Home/cell #_____ Work #_____ email_____
Date of birth_____ SS#_____ Date of injury_____
☐Female ☐Male ☐Single ☐Partnered/Married ☐Other
Referring Health Care Provider_____ phone#_____
Address_____ City_____ State_____ Zip_____

Insurance Information

Insurance Co. (yours or the car you were in)_____
Insured's name (if other than you)_____
Ins Co Address_____ City_____ State_____ Zip_____
Claim #_____ Adjuster's name_____ phone #_____
PIP policy amount_____ dates of coverage_____ PIP available_____
MedPay policy amount_____ dates of coverage_____ MedPay available_____
Liability policy amount_____ dates of coverage_____ Liability available_____
At-Fault Party's Ins Co_____ Insured's name_____
Ins Co Address_____ City_____ State_____ Zip_____
Claim #_____ Adjuster's name_____ phone #_____

Attorney Information

Name_____ Firm_____ Date retained_____
Paralegal/Contact person_____
Address_____ City_____ State_____ Zip_____
Phone #_____ Fax#_____ email_____

the health information form. Although it may be redundant for the patient to provide the information twice, it is helpful for you to have the necessary information at your fingertips when filing insurance forms. Other data might appear to be in duplicate but, in fact, may be completely different information. It is critical to include the contact information for the referring or attending HCP on the billing information, even though there is a similar question on the health information form. The HCP listed on the health information form may not be the attending provider for the current injury. For example, the patient's general practitioner may be listed on the health information form, but the patient's chiropractor is the referring HCP for the motor vehicle case. Know who to contact to renew prescriptions. The prescriptions must come from the attending HCP for the case or the bills may be denied or payment, delayed.

Only the MVC billing information form gathers attorney contact information (see Figure 8-1). Litigation is common in MVC cases, and the patient may have retained an attorney to assist with the case. The attorney may monitor the bills and collect and send bills from all the HCPs to the insurance company or simply wish to stay apprised of the billing status. Know where to send the bills and to whom. Having a direct contact expedites the payment process.

Secondary insurance information should be collected for both MVCs and for private health insurance cases (see Figures 8-2 and 8-4). If the benefits of one plan are exhausted or the services are not a covered benefit, a secondary plan may kick in and cover the expenses.

Assignment of Benefits and Release of Medical Records

The upper portion of the CMS 1500 billing form is for patient identification and insurance information, as well as for two signatures of the patient: one to authorize the insurance company to pay the provider directly (assignment of benefits) and the other to authorize the provider to release medical records to the insurance company for the purpose of processing claims (release of medical records). It is acceptable to obtain the patient's signature and keep it on file rather than have the patient sign every billing form you send out. The signature at the bottom of the billing information form serves this purpose (see Figure 8-5).

FIGURE 8-5. Billing Information—Payment Policies and Authorization

Verification Instructions

My signature below authorizes and directs payment of medical benefits for services billed to my health care provider: _____

Release of Medical Records

My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims. (I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney.)

Financial Responsibility

It is my responsibility to pay for all services provided. In the event that my insurance company denies payment or makes a partial payment, I agree to be and remain responsible for the balances. It is also my understanding and agreement that if you have contracted with my insurance company at a discount rate and the agreed-upon fee has been satisfied, the balance owed on those specific visits will be waived.

Signature _____ Date _____

An attorney retained for litigation in a personal injury insurance case may ask the patient to sign an exclusive medical release form that restricts the release of health care information to the attorney only (refer to Figure 3-3 for an example). This means that the signature on all medical release forms, including the one on the billing information form, is null and void. The intent here is to prevent the insurance company of the at-fault party from obtaining information without the knowledge and consent of the attorney. Verify the date of the patient's signature and compare it with the one on the attorney's form before sending out information.

Financial Responsibility

It is appropriate and legal to remind patients that they are financially responsible for your services, even though the insurance company is expected to pay for the treatments. Ultimately, the patient is responsible for the balance due if the insurance reimbursement is denied or reversed or if partial payment is considered payment in full. If you have contracted with the insurance company at a discounted rate, then you cannot, by the terms of your contract, seek payment from the patient for the remaining amount. Otherwise, the patient is responsible for the balance. Make sure they sign your payment policy, acknowledging responsibility, and keep that on file (refer to Figure 8-5).

Payment Policies

Additional payment policies can be added to your billing information form that state the payment methods available and clarify the type of insurance reimbursement you will accept and under what circumstances. Insurance reimbursement arrangements vary from manual therapist to manual therapist, from state to state, and from country to country, depending on the scope of practice of the individual therapies and the insurance climate of the region. Inform yourself about the specific risks and benefits of insurance billing for your unique situation before setting a policy.

Here is an example of a policy statement to use when billing a patient's automobile insurance company:

The usual policy of this office is for patients to pay for services as they are rendered. In the case of an automotive insurance claim, the therapist may exercise the option of billing your insurance company directly for your health care treatments. Payment is ultimately your obligation, regardless of insurance or other third-party involvement.

It is the policy of this office that your payment of the therapist's fees may be deferred until your personal injury claim is settled or a judgment is obtained, *provided the following conditions are fully satisfied*:

- The therapist retains the option to request that you be represented by an attorney who specializes in personal injury law.
- A guarantee of payment for health care services contract is signed by you *and* your attorney. This permits the therapist's fees to be paid from the final settlement when obtained.
- The merits of your personal injury claim are established by your attorney and communicated to the therapist.
- All accounts not paid in full within 60 days of the date billed will be charged interest. Interest rates are calculated at 12% annually and are charged at 1% monthly. Interest is calculated on the principal amount; interest is not compounded.
- You will be charged for any appointments missed without 24-hour notification of cancellation (this office does not charge the insurance company for missed appointments).

- You acknowledge responsibility for all outstanding payments should the insurance company refuse to pay for services rendered.
- You make a good faith payment for services on a monthly basis until your claim is concluded.

It is acceptable to charge interest on past due accounts. Many states have laws regarding interest terms and start dates, as they apply to medical services, such as 12% per year simple interest beginning 60 days after the billing date. Know what those are in your state and specify your terms clearly. It is generally mandated that the patient be made aware of interest rates in writing before the rates accrue.

Timing and Application

This form should be completed and insurance coverage verified before treatment is provided without immediate payment or as otherwise stated in your payment policies. Unless the insurance coverage changes, the form only needs to be completed once per incident.

Every patient who wants the insurance company to pay the manual therapist directly for health care treatment fills out the billing information form and completes the insurance verification: patient form.

Insurance Verification Form and Worksheet

The insurance verification form helps inform the patient of their benefits and clarify their financial responsibility regarding deductibles and co-pays. The verification worksheet helps the provider verify which massage therapy services are billable, identifies possible restrictions on the services and fees, and confirms items that need to accompany billing statements to ensure ease of reimbursement (see Figures 8-6 and 8-7).

Send the insurance verification: patient form in advance of the patient's first session. If the completed form is not presented at the first appointment, request that the patient pay for the session in full to eliminate your risk. It is risky to extend billing services without having the patient verify coverage. Communicate your policy up front—payment is due at time of service until the form is completed and coverage has been verified—to prevent possible misunderstandings and to motivate the patient to come prepared to the initial visit. If you choose to extend billing services before the patient verifies coverage, emphasize that the patient is responsible for the balance if the insurance claim is denied or if partial payment is made. They agree to this when signing the billing information form, but it is helpful to remind them of their financial responsibility.

Once the patient has verified coverage, you may choose to call the insurance company to confirm the co-pay and remaining deductible, if any, and charge the patient accordingly at the time of service. Collect the co-pay at each session or collect payment in full until the deductible is met.

Use the verification worksheet to help prompt you to gather additional information from the insurance representative: the items the insurance carrier requires to accompany the billing statements, such as prescriptions, progress reports or treatment notes, and the services—techniques and modalities making up your treatment session—that are reimbursable (see Figure 8-7). This worksheet lists common CPT® codes that refer to techniques, modalities, and evaluations performed by manual therapists and prompts you to identify the specific limitations for each. The worksheet does not list every modality and therapeutic procedure found in the Physical Medicine

FIGURE 8-6. Insurance Verification—Patient Form

Provider

INSURANCE VERIFICATION-PATIENT FORM

Patient Name _____ Date _____

Date of Injury_____ ID#/DOB _____

Verification Instructions

Our office is set up to receive direct payment from insurance companies. For the best chance of reimbursement from your insurance carrier, we ask that you:

• Call the number on the back of your insurance card and determine your manual therapy coverage and provider stipulations. Coverage depends on your insurance company and the specific plan you have chosen. Below are the questions for you to ask your insurance representative that will help you determine the amount of coverage available and identify your financial responsibilities so that you may budget for your manual therapy services.

• Record the name of the person you speak with and the time and date of the call for future reference, if necessary. You may need to contact them in the future if it becomes necessary to contest the reimbursement amount.

• Obtain a current prescription for manual therapy from a primary health care provider, such as a physician or a chiropractor. The prescription must include a diagnosis, the type of treatment prescribed, and the frequency and duration of the treatment. The date of the prescription and the duration of treatment as prescribed must cover all dates of service that are to be billed.

• All deductibles and co-pays are due at the time of service. Know what they are and come prepared to pay at your appointments. Cash, checks or VISA/MC accepted.

• Remember, all services provided are ultimately your responsibility regardless of insurance reimbursement. Any dates of service that are not covered by the prescription or that do not fall within your insurance plan's covered services will be billed back to you.

Questions for the insurance representative

Name of Representative _____ Date _____ Time _____

1. Does my insurance plan cover massage therapy? ☐ Yes ☐ No
2. Does it cover massage therapy provided by a licensed massage therapist (or insert other designation, ie: LMP, RMT, CMT, or bodywork credential)_____? ☐ Yes ☐ No
3. Does it cover massage therapy for this condition (insert your condition, such as fibromyalgia or whiplash, use ICD-9 code if possible)_____? ☐ Yes ☐ No
4. Does the treatment have to be referred? ☐ Yes ☐ No
5. Does the treatment have to be prescribed? ☐ Yes ☐ No
6. Who can refer/prescribe massage therapy? ☐ MD ☐ DC ☐ ND ☐ PA
7. Does the plan require pre-authorization? ☐ Yes ☐ No
8. Who is responsible for pre-authorization? ☐ referring provider ☐ massage therapist
9. What is the annual massage therapy benefit limit? ($ amount and/or # of visits) _____
10. Do the benefit limits include treatment by a PT or DC as well? ☐ Yes ☐ No
11. What is the deductible?_____ Has it been met? ☐ Yes ☐ No If no, how much is remaining?_____
12. Is there a co-pay? ☐ Yes ☐ No If yes, how much?_____
13. Does the massage therapist have to be a Preferred Provider? ☐ Yes ☐ No
14. Is (insert therapist's name)_____ on the list? ☐ Yes ☐ No
15. Are there out-of-network benefits available? ☐ Yes ☐ No If yes, what %?_____ Is the deductible the same? ☐ Yes ☐ No If no, the amount?_____ Is the annual massage benefit the same? ☐ Yes ☐ No If no, the $ amount and/or # of visits?_____
16. What is the address, phone # and fax # the authorization, claims and reports should be sent to?

_____

_____

FIGURE 8-7. Insurance Verification—Practitioner Form (CPT [Current Procedural Terminology] codes come from American Medical Association, CPT Intellectual Property Services, 515 N. State Street, Chicago, IL 60610)

Provider

VERIFICATION WORKSHEET

Patient Name _____ Date _____

Date of Injury _____ ID#/DOB _____

Verify Physical Medicine and Rehabilitation Services
(Common modality codes and procedure codes for manual therapists.)

Verified?	Code #	Description	Restrictions	Max Rate
☐ Yes ☐ No	97161	New patient level 1 evaluation		
☐ Yes ☐ No	97162	New patient level 2 evaluation		
☐ Yes ☐ No	97163	New patient level 3 evaluation		
☐ Yes ☐ No	97164	Established patient re-evaluation		
☐ Yes ☐ No	95831	Muscle testing, ROM, manual, with report		
☐ Yes ☐ No	97010	Hot or cold packs		
☐ Yes ☐ No	97110	Therapeutic exercise		
☐ Yes ☐ No	97112	Neuromuscular reeducation		
☐ Yes ☐ No	97113	Aquatic therapy		
☐ Yes ☐ No	97116	Gait training		
☐ Yes ☐ No	97124	Massage therapy		
☐ Yes ☐ No	97140	Manual therapy: eg, mobilization/manip., MLD, MFR, manual traction		
☐ Yes ☐ No	97050	Therapeutic procedure(s), group (2 or more)		
☐ Yes ☐ No	99056	Home/Hospital visit		
☐ Yes ☐ No	99075	Medical testimony		
☐ Yes ☐ No		Other:		
☐ Yes ☐ No		Other:		
☐ Yes ☐ No		Other:		

Which forms should accompany the HCFA 1500? ☐ Prescription ☐ Chart notes ☐ Reports

See CPT codebook for detailed descriptions of modalities and procedures listed above and for additional modalities and therapeutic procedures not listed on worksheet.

and Rehabilitation section of the CPT® codebook, but it is more than sufficient for most manual therapists across the country. Additional space is provided for more codes should one of your reimbursable services be missing from the form. This form is too complicated to ask the patient to complete for you and contains information essential to billing accurately.

If, for example, you are a massage therapist in New York, several massage therapy procedural codes fall within your scope of practice. However, the patient's insurance plan may not reimburse for all the codes available to your profession. Check out each CPT® code individually with every insurance plan. If you are a contracted provider for the plan, the reimbursable codes will be specified in the published fee schedule. If this is the case, simply fill in the spaces provided on the worksheet according to your contract. If not, verify coverage of the techniques and modalities you provide in your treatment sessions.

It is imperative to know the services that are reimbursable under each patient's plan and to clearly understand the restrictions on those services to submit clean claims and ensure prompt payment. For example, workers' compensation may include Swedish massage, neuromuscular reeducation, and cold packs as billable services but may require that these be bundled under the single code 97124 for massage. Without understanding this information adequately, one might submit a bill with incorrect CPT® codes—97112 and 97010—and the bill would be denied. Payment could be delayed 30, 60, or 90 days (perhaps longer) before the misunderstanding is resolved.

Before ending the call, confirm that bills will be submitted on a CMS 1500 form. All insurance companies are obliged to accept CMS 1500 billing forms, but some may prefer electronic billing or customized forms. Make sure you use the updated CMS 1500 that includes the changes post ICD-10. Carriers that prefer electronic billing generally provide the software necessary to comply with their systems. A few companies prefer forms to be customized with their own bar code tracking system. Insurance carriers that require a special form generally provide them to you free of charge. Remember, once you transfer health care information electronically, you must comply with HIPAA regulations, which are addressed in Chapter 5, Documentation: Intake Forms.

Find out whether copies of the patient's file should accompany the bills. If so, find out which records should be copied, such as treatment notes, progress reports, prescriptions, and the like. Some contracts stipulate that the practitioner is to send copies of the patient's file on request. The patient's signature authorizing the release of the file is not necessary in this case. If you are not under contract to provide the patient's information, make sure you have the patient's written consent before sending confidential information.

Ask about the expected turnaround time for payment. Inform the insurance representative of your fees, if they are not already determined by contract. Find out whether any further information would assist in ensuring timely payment. You might want to ask about common mistakes that delay payment and tips on how to avoid making those mistakes.

Send a letter confirming the patient's benefits and applicable services (see sample in Figure 8-8). Verbal or online authorizations are sufficient for reimbursement, provided the claim is complete and accurate, but the confirmation letter ensures that the insurance carrier has the authorization documented and on file when you get authorization by phone. This is not required, but having the documentation proves invaluable when a dispute arises.

Monitor Prescription Renewals

Once you have verified the insurance information and coverage, you are ready to provide treatment and bill for the services. Repeat the verification process with each request for ongoing services beyond the number of sessions and dates of service previously authorized. First, write a progress report to the referring HCP requesting a prescription for additional treatment. Once the prescription has been received, call the insurance representative to verify additional benefits necessary to cover the ongoing

FIGURE 8-8. Confirmation Letter

Helena LaLuna, CR
123 Sun Moon and Stars Drive
Capitol Hill, WA 98119
PHONE 206 555 4446 • EMAIL laluna@email.com

Dear Aziz Amaden:

Thank you for the phone conversation regarding services for Zamora Hostetter.

This letter confirms the details of our conversation:

1. Manual therapy is a covered benefit for the following diagnosis: 724.2
723.1, 840.9, 728.85, 784.0
2. The following CPT codes are authorized for the following rate: 97140 @
28.78 per unit maximum 4 units per tx
3. 6 sessions are authorized to be completed between 4-1 → 5-1-17.
4. The patient's co-pay/co-insurance amount of $ 0 will be collected from the patient at the time of service.
5. ☒ Prescription ☐ SOAPs ☒ Progress reports ☐ License/Certification
will accompany each billing statement.
6. Payment is anticipated within 30 days of receipt of a clean claim.
7. If ongoing care is deemed necessary by the referring HCP, re-authorization will be requested by 4-24-17 to ensure no break in care for the patient.
8. All claims will be sent to: WA. Dept. of L & I
Attn: claims department Address PO Box 323 Olympia WA 98055

If you have any questions, please call. If I do not hear from you within 24 hours of receipt of this letter, I will assume that reimbursement for services is confirmed.

Sincerely,

Helena La Luna, CR

care and to authorize your services. Confirm that the ICD-10 codes provided on the new prescription are covered under the patient's plan and that they warrant your services. Record the authorization from the insurance company and the dates of service prescribed by the referring HCP on the patient's payment log (see online, Appendix B for Blank Forms).

There are insurance plans that do not require a prescription to bill for manual therapy services. These are few and far between, but problems arise in these instances. All insurance plans require ICD-10 codes to bill for services. If you do not have diagnostic scope, you cannot assign ICD-10 codes to a patient. For example, cases have arisen where massage therapists are accused of operating outside their scope. Avoid disciplinary actions and require a prescription with ICD-10 codes regardless of the insurance plan leniencies.

TALES FROM EXPERIENCE

Speak with Authorizing Physician Directly

Jayne faxed over an authorization request for an additional set of massage sessions to a self-insured workers' compensation claims office. The fax that she received in response denied her request. She was stunned; this was a patient with a serious debilitating injury, and he was making good progress with treatment. The referring physician had sent a new prescription that Jayne included in her fax, stating the treatment was medically necessary. Rather than accepting the decision, she called the claims office and asked to speak with the physician who signed the denial.

The physician answered his phone. He did not remember having seen the faxed information. Jayne waited while he found the chart notes, prescription, and request. On reviewing the documents while on the phone, he authorized the request. Jayne asked why it was initially denied. He said, "The girls at the fax machine must not have seen the key words they were looking for to accept the request."

There are so many things wrong with this true story, the first of which is that a medical auditor never even looked at the request. Call, speak politely, and see if you can reverse those decisions that seem mistaken.

Monitor Attorney Contracts, Liens, and Requests for Records

If the patient has retained an attorney for a personal injury case, log and monitor all pertinent information regarding payment contracts, liens, and requests for medical records. If PIP, MedPay, or other secondary coverage is exhausted or nonexistent, file liens on the case with copies mailed to the insurer, patient, and attorney as per the requirements of state law. For example, in the state of Washington, health care liens must be renewed every 6 months from the date filed. Health care liens may need to be renewed before expiration dates; note the date filed and the dates renewed. Note the date the contractual guarantee was requested from the attorney and the date it was returned and filed. Note the expiration dates of authorizations to release medical information and ensure (by monitoring) that requests for records fall within the authorized dates. Log the date the requests were received and the date the information was mailed.

If the insurance coverage is not straightforward and the patient was not able to complete the billing information form to your satisfaction, ask the attorney to complete the insurance status form (see online, Appendix B). Consult the attorney to verify coverage and to authorize services.

Guidelines for Insurance Billing

THE CENTERS FOR MEDICARE AND MEDICAID SERVICES 1500 BILLING FORM

The **CMS 1500 form** is the standard billing form approved by the AMA (see Figure 8-9). The insurance information form and the insurance verification form provide information necessary to complete the form, which is divided into two parts: patient and insured information and provider information. It is fairly self-explanatory, but some sections can be confusing or do not apply to manual therapists. Each section is numbered and corresponds with the explanation that follows it. This form was updated in 2014 before the implementation of the ICD-10 codes. Owing to the increased specificity of ICD codes, spaces have increased from 4 to 12 to allow for additional codes.

Box 1.	Check the box that applies to the type of insurance for the patient. For health insurance, check the group health plan box and write either the patient's social security number or the insurance identification number (box 1a). For personal injury cases or worker's compensation cases, check the other box and write the claim number (box 1a).
Boxes 2–7.	Fill in the patient's name, address, and telephone number (boxes 2 and 5) and birthdate and gender (box 3). If the patient is also the insured, record "Same" as the insured's name (box 4). If the insured is someone other than the patient, fill in the insured's name, address, and phone number (boxes 4 and 7). For example, Darnel's nephew was the owner of the car in which Darnel was riding when the accident occurred. Therefore, you would fill in the nephew's name, address, and phone number as the primary insured. The nephew's insurance is first in line to cover Darnel's medical expenses. A common situation in which the insured is not the patient occurs when the spouse is insured through work and the insurance policy covers the patient. Check the box that signifies the patient's relationship to the insured (box 6). NOTE: Some plans refer to the patient as the primary insured, even if the policy originates with a spouse or parent, as long as their own name is on the card. This is the case when each family member is assigned a different number.
Box 8.	Self-explanatory.
Box 9.	Other insured refers to second-party coverage. For example, this may be the patient's car insurance if the primary coverage is someone else's, or it may be the patient's health insurance if the car insurance does not provide PIP. Darnel's other insured, or secondary coverage, is his own automobile insurance. If the patient does not drive and does not carry auto insurance, his health insurance is considered the other insured.

FIGURE 8-9. CMS (Centers for Medicare and Medicaid Services) 1500 Billing Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): C98-7654321

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Hostetter Zamora

3. PATIENT'S BIRTH DATE MM DD YY: 05 22 96 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): same

5. PATIENT'S ADDRESS (No., Street): 63 18TH Ave W

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Capitol Hill STATE: WA

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 98119 TELEPHONE (Include Area Code): (206) 555-1221

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): same

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 555-63-1819

a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: Howling Moon Cafe

c. EMPLOYER'S NAME OR SCHOOL NAME: Howling Moon Cafe

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: WA Dept. L & I

d. INSURANCE PLAN NAME OR PROGRAM NAME: Health Co Selections

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: signature on file DATE: 4-4-17

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: signature on file

14. DATE OF CURRENT: MM DD YY: 03 31 17 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Manda Rae Yuricich, DC

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 724.2
2. 723.1,784.0
3. 840.9
4. 728.85

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	4 4 17	4 4 17	11	9	97140		1,2,3,4	25	1		NPI 1234567890
2	4 4 17	4 4 17	11	9	97140		1,2,3,4	25	1		NPI 1234567890
3	4 4 17	4 4 17	11	9	97140		1,2,3,4	25	1		NPI 1234567890
4	4 4 17	4 4 17	11	9	97140		1,2,3,4	25	1		NPI 1234567890
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 91-1777771

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE: $ 100

29. AMOUNT PAID: $ 0

30. BALANCE DUE: $ 100

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Helena La Luna, CR 4-4-17

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (206) 555-4446

Helena La Luna, CR
123 Sun Moon and Stars Dr.
Capitol Hill, WA 98119

a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Box 10.	Self-explanatory.
Box 11.	Fill in the insured's applicable policy number. This might be the group insurance number or the plan number, whichever identifies the type of plan carried by the insured. Fill in the date of birth and sex (11a). The name of employer or school (11b) is necessary only when the insurance plan is provided through one of them. Personal injury cases do not require this information unless the injury occurred while the patient was working. Fill in the plan name (11c) and answer the question regarding secondary insurance coverage (11d). NOTE: Sex (gender) identification may be problematic, even when the legal sex status has been changed. The patient may need to double-check that the sex status is up to date in the insurance database.
Box 12.	The patient is required to authorize the release of any medical information necessary to process the claim. The patient does not have to sign every billing form if he or she has signed a release on file in the chart. This release is included on the billing information form. Make sure the patient signs the release when he or she fills out the form and note "Signature on File," rather than having the patient sign every bill. The date for this section should reflect the date the patient signed the insurance information form.
Box 13.	Here, the patient's signature authorizes the insurance company to pay the HCP directly. Payment will be written and mailed to the provider shown in box 33, which is also included on the billing information form. Again, rather than requiring the patient to sign every bill, recording "Signature on File" will suffice (when the patient's signature is on the intake form).
Boxes 14 and 15.	Self-explanatory.
Boxes 16 and 18.	These may not apply to adjunctive care and can be left blank. The referring HCP can complete this information on their billing form.
Box 17.	Fill in the referring HCP's name and NPI provider number, if applicable. (Your NPI# does not go there. Record yours in box 24J.)
Boxes 19 and 20.	Leave blank.
Box 21.	Most insurance carriers require a diagnosis to reimburse for services, regardless of your ability to diagnose. If diagnosing is not within your scope of practice, simply transfer the diagnosis from the prescription to the CMS 1500. Filling in the diagnosis code (ICD-10) on a CMS 1500 form will not be construed as acting outside your scope of practice, as long as a referring HCP provided the codes for you and the prescription is on file.

Boxes 22 and 23. Leave box 22 blank unless you are billing Medicaid.Leave box 23 blank unless the patient's insurance requires prior authorization to bill.

Box 24. The date(s) of service column displays a From section and a To section (box 24A) in which you record the date (or dates) on which you provided the service (repeat the same date in both sections). The codes in the place of service column (box 24B) vary among carriers and may be found in the company's billing manual. Some , such as the following, use numbers:

1. Inpatient hospital
2. Outpatient hospital
3. Office
4. Residence
5. Emergency room
6. Other medical/surgical facilities
7. Nursing home
8. Other location
   Or
9. Office
10. Home
11. Hospital
12. Outpatient hospital
13. Ambulatory surgical center
14. Birthing center
15. Custodial care facility
16. Hospice

Others use letters: AC, ambulatory surgical center; ER, emergency room; HM, patient's home; HS, hospice; IH, inpatient hospital; NH, nursing home; OH, outpatient hospital; OF, practitioner's office. Check with the insurance representative for the preferred codes or request a billing manual to ensure accurate billing. The type of service column also varies among insurance carriers (box 24C). The following is one example of a carrier's code list:

1. Medical care
2. Surgery
3. Consultation
4. Diagnostic X-ray
5. Diagnostic laboratory test results
6. Radiation therapy
7. Anesthesia
8. Surgical assistant
9. Other medical services

Again, check with the insurance carrier for its preferred codes. The services you bill for must be listed by CPT code unless state regulations dictate otherwise (box 24D). CPT codes are the standard according to the AMA and are typically required for insurance reimbursement for health care services. Refer to the list on the insurance verification worksheet for each patient and use the codes that describe your services, that are within your scope of practice, and that are reimbursable within the patient's plan. The diagnosis codes are numbered in box 24E. Fill in the number that corresponds to the diagnosis of the conditions that you treated in the session, and make sure you include modifiers when necessary. For example, the patient might have two conditions—lower back pain and cervical subluxation—and two diagnosis codes listed for each condition. Last Tuesday, you treated the lower back pain only and did not have time to treat the neck condition. For that session, you would fill in the numbers 1 and 2 (shown as 1, 2 in column). This Monday you were able to address both conditions and put 1, 2, 3, 4 in the column. Charges should reflect the total amount for the line item (box 24F). A common mistake is to give the value of one unit of service rather than the total for all units of service. If, for example, you provided four units of the service listed and each unit is billed at $25 per unit, the total charges would be $100. Days or units (box 24G) refer to a designated period of time or a single, specified procedure. Each CPT code lists a unit of time in the description. Some are 15-minute units; others are 30-minute units. If no unit of time is provided in the description, the CPT code refers to the procedure as a single unit, independent of the amount of time it takes to perform the procedure. For example, hot and cold packs may be applied as a procedure undefined by time, whereas neuromuscular reeducation is billable in 15-minute units and an extended new patient office visit is defined as a 45-minute unit. Refer to the CPT codebook for the definition of units to ensure accurate billing for your services.

Boxes 24 H and I	Leave blank.
Box 24 J	You must apply for an NPI# before billing insurance. Record your NPI# here.
Box 25	Self-explanatory.
Box 26	Giving this information is optional. If you organize your office records by assigning your patients numbers, put the patient's number here to assist you in filing the bills.
Box 27	Leave blank.
Box 28	Total all the charges for each line item.
Box 29	Fill in any payments paid by the patient, such as a co-pay.
Box 30	Fill in the balance due.

Box 31	Self-explanatory.
Box 32	Increasingly, insurance companies are requesting that this box be completed even when it is the same address as in box 33. Make sure this address is the physical location where services were performed and not a post office box or the billing address of a billing service that submits the bills and collects the payments. Include the NPI# of the clinic, which is likely different than your NPI#, if you are practicing within a larger business (32A).
Box 33	Make sure this information is legible. Checks will be made payable to the name listed here and sent to the address listed here. Include your NPI# (33A), or the NPI# of the clinic when multiple practitioners are treating the same patient. If there are any questions regarding the bill, a bill processor may prefer to call you before denying the bill or sending it back in the mail.

TIMING

Submit the CMS 1500 billing form immediately after the first session. If there are any problems with the billing procedures, it is best to work out the glitches early in the reimbursement process. The most common delay in billing is a simple lack of information, such as failure to attach a copy of the prescription or providing an inappropriate diagnosis code. Once complete and accurate information is provided, the billing usually proceeds smoothly.

Bill often. Many computerized billing programs make it easy to bill after each session. Other practitioners designate 1 day each week or so for office work and to do all their billing, report writing, and correspondence. Whichever approach you choose, make sure you bill treatment dates within the same month. It is easier on the other end to organize and track reimbursement when all dates of service fall within a calendar month. This may be stipulated in your contract under billing procedures.

Do your billing frequently to avoid reimbursement delays, especially on high dollar amounts, which often require additional signatures or higher authority to authorize payment.

Rebill every 30 days for the balance due. Stamp the CMS 1500 form with the notation: COPY—RESUBMITTED (provide date of resubmission). Attach an invoice adding interest charges, if applicable, and state the new balance. If you are a preferred provider under contract with the carrier, check your contract for stipulations regarding interest. Moreover, check for state regulations regarding interest charges on medical services. For example, the state of Washington limits interest on medical services to 12% simple interest annually or 1% per month applied only to the treatment amount. In other words, HCPs may not apply interest to interest. Typically, providers are not able to accrue interest until 90 days after the billing date. Provide the patient and the insurance company 30 days' notice before assigning interest and calculate the interest according to state regulations.

PAYMENT AND CORRESPONDENCE LOGS

Computerized billing will track payments automatically. Regardless, create a payment and correspondence log for each patient (Figure 8-10) to help you track treatment and billing dates, and reimbursement dates and payment amounts. There are six lines on the CMS

FIGURE 8-10. Payment Log

Helena LaLuna, CR
123 Sun Moon and Stars Drive
Capitol Hill, WA 98119
PHONE 206 555 4446 • EMAIL laluna@email.com

PAYMENT LOG

Name Zamora Hostetter Date 6-18-17

Date of Injury 3-31-17 ID#/DOB C98-7654321

Insurance Company _____ Phone _____

Billing Date: 5-18-17 Total Billed: $ 100

Patient Paid: $ 0 Insurance Paid: $ 0 Total Paid: $ 0

If Total Paid does NOT equal Total Billed, complete below for each date of service (from lines 1-6, Section 24 of HCFA 1500)

Line 1, Initial Billing Prescription: 1/6
Treatment Date: 5-18-17 Bill Date: 5-18-17
Charges: 100 Adjustments: 0 Amount Billed: 100
Due from patient: 0 Due from Insurance: 100-
Patient Paid: 0 Insurance paid: 0

Line 1, Rebilling
Rebill Date: 6-18-17 Rebilled to: Ins.
Outstanding: 100- Interest: 0 Amount Billed: 100-
Rebill Date: 7-18-17 Rebilled to: Ins.
Outstanding: 100- Interest: 1% Amount Billed: 101-

Line 2, Initial Billing Prescription: _____
Treatment Date: _____ Bill Date: _____
Charges: ____ Adjustments: ____ Amount Billed: _____
Due from patient: _____ Due from Insurance: _____
Patient Paid: _____ Insurance paid: _____

Line 2, Rebilling
Rebill Date: _____ Rebilled to: _____
Outstanding: _____ Interest: _____ Amount Billed: _____
Rebill Date: _____ Rebilled to: _____
Outstanding: _____ Interest: _____ Amount Billed: _____

Line 3, Initial Billing Prescription: _____
Treatment Date: _____ Bill Date: _____
Charges: ____ Adjustments: ____ Amount Billed: _____
Due from patient: _____ Due from Insurance: _____
Patient Paid: _____ Insurance paid: _____

Line 3, Rebilling
Rebill Date: _____ Rebilled to: _____
Outstanding: _____ Interest: _____ Amount Billed: _____
Rebill Date: _____ Rebilled to: _____
Outstanding: _____ Interest: _____ Amount Billed: _____

Line 4, Initial Billing Prescription: _____
Treatment Date: _____ Bill Date: _____
Charges: ____ Adjustments: ____ Amount Billed: _____
Due from patient: _____ Due from Insurance: _____
Patient Paid: _____ Insurance paid: _____

Line 4, Rebilling
Rebill Date: _____ Rebilled to: _____
Outstanding: _____ Interest: _____ Amount Billed: _____
Rebill Date: _____ Rebilled to: _____
Outstanding: _____ Interest: _____ Amount Billed: _____

Line 5, Initial Billing Prescription: _____
Treatment Date: _____ Bill Date: _____
Charges: ____ Adjustments: ____ Amount Billed: _____
Due from patient: _____ Due from Insurance: _____
Patient Paid: _____ Insurance paid: _____

Line 5, Rebilling
Rebill Date: _____ Rebilled to: _____
Outstanding: _____ Interest: _____ Amount Billed: _____
Rebill Date: _____ Rebilled to: _____
Outstanding: _____ Interest: _____ Amount Billed: _____

Line 6, Initial Billing Prescription: _____
Treatment Date: _____ Bill Date: _____
Charges: ____ Adjustments: ____ Amount Billed: _____
Due from patient: _____ Due from Insurance: _____
Patient Paid: _____ Insurance paid: _____

Line 6, Rebilling
Rebill Date: _____ Rebilled to: _____
Outstanding: _____ Interest: _____ Amount Billed: _____
Rebill Date: _____ Rebilled to: _____
Outstanding: _____ Interest: _____ Amount Billed: _____

1500 for billing either six different services or six different treatment dates, if only one service is provided on each date. The payment log also provides six services or treatment dates. Record each service or treatment billed for on the payment log separately to better monitor payments. These logs can be kept separate from the patient's chart. You might elect to keep a separate database for all patient financial information that is HIPAA compliant.

Track prescriptions on the same form, ensuring all treatment are covered and the dates fall within authorized timelines. If a prescription is for six sessions, the first treatment will be the first of six prescribed visits or 1/6. The second treatment date billed will be marked 2/6 and so on.

The person in charge of billing may choose to file all payment logs in a three-ring binder in alphabetical order. Go through the binder twice monthly to determine whom to rebill at 30-day intervals. This is an effective strategy for tracking paper logs. There are software systems that can organize and track your billing online if you do everything electronically.

Enter all payments into the logs before depositing funds. Verify the dates of service for each reimbursement check. This is a critical step. Each check will specify the dates of service to which the payment applies on the EOB statement. Sometimes, a partial payment may be made. When rebilling, it is important to know which of the three treatments billed was miscalculated. If you simply apply it to the last treatment date, it will not show up in the system as unpaid or partially paid, and you will not recover the funds. Another common mistake is when the current payment doesn't follow the treatment dates for the previous payment. For example, Helena sent three billing statements to HealthCo. The first bill was for treatment provided on April 12. The second bill was for treatments on April 15, 18, and 21. The third bill was for treatment on May 1. The first payment received was for treatments on April 15, 18, and 21, skipping a payment for April 12. The second payment received was for the May 1 treatment. Helena erroneously applied the payments chronologically on the payment log. After Helena resubmitted a modified bill for May 1 instead of April 12, HealthCo informed her that she had been paid already for services provided on May 1, and the company refused to pay. Helena cannot contest the situation successfully until she resolves the misapplied amount.

Use the form to log prescriptions and monitor the number of sessions covered by the prescriptions. Ensure that the prescriptions cover the dates of treatments. Gaps in prescriptions can be costly to you and your patient. For example, Darnel's physician wrote a prescription for six treatments in a 4-week period beginning on April 4th. Only four treatments were provided in the time allotted, with the additional two provided the following week. The new prescription was dated May 16th. The two treatments provided between May 4th (the date the previous prescription ended) and May 16th (the date the new prescription started) are not covered by either prescription and therefore may not be reimbursable by the insurance company. Avoid costly mistakes by tracking the prescriptions on the insurance verification form.

In addition, track the number of visits provided against the number authorized, regardless of the prescription. State-insured and self-insured workers' compensation insurance typically authorizes massage therapy in series of six sessions. Private health insurance plans that require preauthorization may only allow three or four treatment sessions at a time. Treatment provided beyond the authorized number of sessions will not be covered. It is unlawful to seek payment from the patient for care provided with most workers' compensation plans; you will not get paid for unauthorized sessions.

It is important to support patients in adhering to the treatment plan and staying on top of the frequency prescribed. Communicate with your patients about the challenges inconsistent care can cause. They are financially responsible for their care should the insurance company deny payment and will feel the repercussions of this in their pocketbook.

Strategies for Managing Reimbursement Challenges

Private health insurance companies are required by law to respond to a designated number of claims within a specified amount of time. (This does not include personal injury insurance or workers' compensation.) Clean claims are paid first: insurance claim bills submitted with complete and accurate information for services that are covered for the patient and that the practitioner is authorized to provide. Unclean claims—claims that lack information or contain disputable information, such as a procedure that is not authorized for the diagnosis—require additional correspondence until all information is obtained before processing.

Ask for clarification whenever a diagnosis code is denied. ICD-10 codes for migraines, for example, might be denied automatically if there is not enough evidence of positive results with massage therapy. If a code is denied, ask the insurance representative for a list of the allowable codes for a particular condition, such as headaches. Then, contact the referring HCP and request that a different diagnosis code be recorded on the prescription. This practice is acceptable as long as it does not misrepresent the patient's diagnosis. Reimbursement for unclean claims can be delayed, denied, or reversed. Most unclean claims are returned to the practitioner for clarification or correction and must be returned clean within a designated time frame to prevent further delay in payment. Other claims require investigation from a utilization management program or review board. Peer reviews determine whether treatment and cost of care were

- Appropriate for the condition
- Effective—resulting in improved quality of life for the patient
- Reasonable

Peer reviewers determine whether claims meet these requirements by studying patient files and looking for answers to the following questions:

- Did the provider deliver the promised services?
- Did the provider deliver the promised services in the agreed-upon time?
- Did the intervention deliver the expected outcome?
- Did the provider charge usual, customary, and regular (UCR) fees for services?

Denied claims may result in partial payment, no payment, or a reversal in payment. Denial resulting in partial payment is often because of the following:

- Treating outside the diagnosis. Raphael treated a patient diagnosed with an ankle sprain by administering massage therapy both to the upper extremities and the lower extremities. The insurance claims processor determined that the treatment was not consistent with the diagnosis and awarded a partial payment. Sixty percent of the

treatment was designated appropriate treatment, and 40% was deemed unnecessary treatment. The partial payment reflected 60% of the total fee for all treatments. Appeals of this type can be successful if the therapist can prove the necessity of care and, in this case, can explain the necessity of treating the upper extremities to benefit the injured ankle.

- Treating outside the time frame authorized for treatments. If authorization was obtained for six sessions within 30 days and the sixth treatment was given on day 32, be aware that appeals caused by scheduling negligence rarely succeed. Become aware of time limitations, as they pertain to your services.
- Treating beyond the standard of care for the condition. If 10 sessions are the maximum allowable for lower back pain and 13 were provided, expect only partial payment. This can be easily avoided by verifying the number of sessions authorized before administering the treatment.
- The patient's benefits changed with the new year/cycle, and the patient was not informed or did not inform the practitioner.

Denial resulting in no payment is common when the practitioner does the following:

- Bills for treatment outside his or her scope of practice.
- Bills for services not authorized for the diagnosis.
- Bills for two or more similar modalities provided on the same day. If the patient receives physical therapy *and* massage therapy on the same day, the practitioner who submits the claim first usually will be the only one reimbursed.

Denial resulting in reversal of payment occurs when the practitioner is found guilty of using fraudulent or abusive billing practices, such as charging for procedures that were not performed, charging for medically unnecessary services, submitting claims with misleading diagnostic codes so as to receive benefits for an excluded service, or billing at a higher rate than would be charged in the absence of third-party reimbursement.

It is illegal to charge different rates for the same service to different people or organizations. It is appropriate, however, to charge different fees for different services or to offer reasonable discounts for payment on the day of service, as long as the discount is offered to all patients equally. For example, if a patient pays cash but is submitting the bill to an insurance carrier for reimbursement, he or she must be offered the same discount at the time of service as any other patient would be offered. Acceptable discounts range between 5% and 20%, depending on state regulations. Consistent across insurance carriers is the fact that billing an insurance company at one rate and cash patients at another is considered fraudulent and abusive, particularly when the cash patient seeks reimbursement at the higher rate.

During peer reviews involving fraudulent billing, all the provider's files are seized and reviewed for consistency. If, for example, the massage therapist clearly charges one fee for wellness massage and one fee for treatment massage, the difference in fees is justified. However, if the review board finds that the practitioner's primary techniques—manual lymphatic drainage and neuromuscular reeducation, for example—are performed equally among relaxation patients and insurance patients, the different fee schedules are not justifiable. The practitioner may be required to reimburse insurance payments retroactively for up to 7 years, depending on the laws of the state.

TALES FROM EXPERIENCE

Usual and Customary Fees

A massage therapist was found guilty of using fraudulent billing practices and was required to reimburse an insurance company about $76,000 in back payments, interest, and penalties. She was not a dishonest person but had misinterpreted the insurance company's fee schedule. She owns a large clinic, misused the 97112 CPT code when billing on behalf of all her therapists over several years, and is required to reimburse the difference between 97140 and 97112. Her negligence in not reading the contract carefully resulted in financial hardship. She will be making payments to make up for this mistake for years to come.

Insurance billing can be risky, and billing challenges are unavoidable. Staying on top of outstanding bills is imperative. Successful strategies for managing insurance reimbursement are covered in the following sections.

PROVIDE COMPLETE AND ACCURATE INFORMATION

Patient information and insurance information must be complete and accurate to avoid delays in payment. Follow these guidelines to avoid challenges regarding patient documentation:

- Record a comprehensive history of each patient.
- Keep treatment charts on every session.
- Make sure the treatments noted reflect the procedures and modalities billed.
- Document measurable subjective and objective data that validate the treatment provided.
- Set goals that reflect measurable progress in the patient's everyday activities.
- Create a treatment plan to accomplish the patient's functional goals.
- Evaluate patient progress regularly (every 30 days or 6–8 sessions or at the end of each prescription, whichever is sooner).
- Adjust the treatment plan to meet the patient's changing needs.
- Date all forms and treatment charts.
- Make sure treatment dates correspond accurately with billing dates.
- Write monthly progress reports.
- Make sure the progress reports reflect information in the treatment charts.
- Write legibly.
- Stamp *your* name, address, and phone number on every page in the patient's file.
- Take notes that are spontaneous and unique to each individual patient.
- Have the patient fill out a billing information form.
- Review the completed billing information form with the patient to verify content.
- Make sure the patient and insured's information, especially the patient's insurance identification number or birthdate and insurance policy numbers, is accurately transposed onto the billing form.
- Require a prescription from the patient's primary HCP, even if they say their plan does not require one.
- In case of an incomplete prescription, provide a prescription form for the referring HCP to complete (or gather necessary information over the phone).
- Have the patient complete the insurance verification form (see Figure 8-6).
- Complete the verification worksheet (see Figure 8-7).

- Verify insurance coverage for your services, given your professional scope.
- Verify patient eligibility for the services, given the diagnosis.
- Inform the insurance representative in advance of your fee, unless dictated by contract.
- Double-check the provider information on the billing form to eliminate most mistakes, such as transposing numbers, giving inaccurate procedure codes, or providing an incomplete diagnosis.
- Make sure the treatment dates on the CMS 1500 billing form correspond with the treatment notes.
- Know what information should accompany the billing form and send it as required, including treatment notes, progress reports, and prescriptions.

STAY WITHIN DESIGNATED TIME LIMITS

Specific requirements must be met by the patient and the practitioner to ensure payment. Many of the requirements revolve around time. Stay within designated time limits when providing treatments, submitting bills, and seeking reimbursement.

- Provide treatment within the time period authorized.
- Make sure prescriptions cover all dates of treatment.
- Submit bills in a timely fashion. Never wait more than 30 days to submit a bill.
- Monitor the time frames for deductibles, when they are satisfied and when they are renewed, and collect appropriate fees at the time of service.
- Record the names, dates, and times of all phone conversations with insurance representatives.
- Resubmit bills after 31 days of no payment. Stamp each bill with the rebilling date and follow up with a phone call.
- Resubmit bills after 61 days of no payment. Include the following statement: "This claim is more than 60 days past due. If this claim is not paid or denied within 30 days, a written complaint will be submitted to the insurance commissioner's office." (See online, Appendix F for contact information regarding insurance commissioners.) Follow up with a phone call.
- Return unclean claims with the requested information as soon as possible.
- Appeal all denied claims within the time limit specified.
- Monitor expiration dates of medical liens and authorizations for release of medical records.
- Know the statute of limitations for filing a lawsuit.

PROVE MEDICAL NECESSITY

Practitioners must be able to support the medical necessity of treatment provided. Although, it is true that only the PCP can prove medical necessity, it is our responsibility to show that our treatment supports the diagnosis and defends our care.

Follow these guidelines to avoid disputes over medical necessity:

- Make sure prescriptions communicate that the adjunctive care is integral to the treatment plan.
- Prove progress specific to the patient's daily activities.
- Treat within the diagnosis. For holistic treatments, ensure that the prescription requests treatment to structures outside the diagnosis, and if denied, you can justify full-body treatment with confidence.

- Document active *and* passive care. Educate patients in self-care, which includes self-massage, breathing exercises, application of hot and cold packs, stretching and strengthening exercises, ergonomics and movement mechanics, and increased awareness of aggravating activities.
- If a formal appeal is necessary, educate the reviewer on the necessity of treatment and the benefits of massage therapy. Some insurers will see complementary care as experimental treatment and not reimbursable. Be prepared to send research articles and to write letters detailing the benefits of massage therapy.

FILE LIENS ON PERSONAL INJURY CASES

Medical or health care liens are used to guarantee payment for treatments provided to people who have sustained a personal injury. The intent is to place a hold on the patient's claim until satisfying the outstanding medical bills. Depending on state law, the HCP must file the lien in a specified way. For example, in Washington, the lien must be filed with the county auditor—the county in which the services were performed, not the county where the MVC occurred—before settlement and payment have been made to the injured party and must conform to strict format configurations.

File medical liens on all personal injury cases in which payment has been deferred. Send copies of the lien to the patient, to the patient's and the at-fault party's insurance company, and the patient's attorney, if applicable.[8]

MISCELLANEOUS REIMBURSEMENT TIPS

These tips address topics and procedures to help minimize delays in reimbursement.

- Establish positive, cooperative relationships with insurance representatives. Your attitude may affect the reimbursement results.
- Read insurance contracts carefully. Follow the contractual language of the policy.
- Correctly apply all payments according to the dates of treatment stated on the EOB.
- Be prepared. Know the standard billing practices and procedure codes for your profession for each type of insurance before agreeing to provide billing services.
- Use computerized billing or complete the information on the CMS 1500 form from a computer, then print and fax. Handwritten bills are difficult to read and will often result in delays.
- Ask the patient to intervene. If the insurance company is delaying payment, a phone call from the patient can speed up claims processing.
- Ask the attorney to intervene. A letter or a phone call can be very effective in prompting payment.
- If necessary, send a request to the office of the insurance commissioner (OIC) to intervene. A formal complaint to the OIC reflects badly on the insurance company and often results in an investigation, the results of which will remain in an insurance carrier's file for several years.
- Require contracts guaranteeing payment from attorney liens or medical liens for all personal injury cases. If the attorney refuses to sign the letter guaranteeing payment from the settlement, stop deferring payment immediately, file a medical lien, and require the patient to make regular payments on the outstanding balance.
- As always, keep your cool. A calm, professional demeanor will work far better than an indignant attitude in all cases.

State regulatory agencies, such as the OIC, may provide additional assistance to manual therapists and patients. Generally, the OIC is there to be an advocate for the consumers, not the providers, and investigates formal complaints against insurance carriers and assists with writing, interpreting, and implementing rules that providers and insurers must follow. These regulations offer support and protection for both the HCP and their patients. In addition, staff members can be strong advocates for patients and providers, by helping patients receive appropriate levels of benefits based on the insurance packages purchased and supporting providers in receiving fair treatment and prompt payment by insurers. Individual provider assistance varies from state to state, so you should become aware of options in your state (see online, Appendix F about contacting state agencies).

Appealing Claims Denials

Claims can be denied before treatment is provided, during treatment (with the frequent result of discontinued care), or after the services have been provided. There is no financial risk to the provider or the patient when a claim is denied before treatment is provided or when the denial simply prevents ongoing care. However, when a claim is denied after the service has been delivered, the provider has financial motivation to appeal the denial to ease the financial hardship not only for himself or herself but ultimately for the patient.

Financial hardship is not the only reason to appeal a claim. You may have a great deal of emotional investment in getting the patient the needed care. You can be successful in appealing denials if a lack of treatment can result in harm to the patient. The process of appealing becomes an opportunity to educate the insurance representatives about the benefits of massage therapy and the patient's level of need.

The denial may be the result of a simple mistake that can be corrected and the denial reversed, or it may be a valid response to an infraction of policy undeserving of an appeal. However, an appeal is warranted if a denial is issued when treatment is critical for the health of the patient and the denial is a result of the insurance carrier's failure to cover the needs of the patient or of the insurance representative's failure to understand the patient's condition and need for care. Appeals are commonly needed for chronic conditions or conditions poorly understood by health professionals and claims managers, such as lymphedema and fibromyalgia. Plans rarely cover chronic conditions because insurers consider treatment for these conditions to be palliative—symptoms do not subside—even though a lack of treatment may result in a substantial decrease in the patient's ability to function and ultimately may leave the patient predisposed to serious acute flare-ups.

Appeals must be written so that they validate treatment based on the patient's specific condition and prove that such care is neither preventive nor palliative and is necessary for the patient's ability to function in everyday activities. Without the treatment, the quality of the patient's life is diminished. For information on resolving disputes related to ICD-10 coding, visit http://www.appeallettersonline.com/letters.php (download sample letters free of charge).

Appeals must be filed within a specified time frame or the appeal does not have to be heard. Level 1 appeals are conducted by a peer review panel. Your peers may not be representative of your profession but typically include nurses or physical therapists—professionals who subsume your scope of practice and oversee all HCPs who fall under physical medicine. If your appeal is denied, you may petition for a Level 2 review. An internal grievance and appeals committee will consider your case at this level. Your final opportunity for

a favorable outcome is a Level 3 review, which is conducted by an external review agency. Every insurance company conducts its appeals a little differently. Refer to your provider contract for rules regarding appeals processes.

TALES FROM EXPERIENCE

Winning Appeals

Karin was pregnant. She had injured her lower back at work and was coming to Lakeside Massage Clinic for massage therapy treatments to ease the pain and muscle spasms in her lower back and supporting musculature. Her pregnancy made it difficult to treat the muscles of her anterior lumbar spine and hip flexors. I used foot reflexology to address the structures I could not treat directly and safely. The insurance company paid for only 68% of the amount billed and refused to pay for foot massage, which the company considered palliative. I filed an appeal, did my research, and wrote a letter explaining the patient's condition and the need for indirect treatment in response to the patient's overriding safety concerns. I also defended my decision to treat the opposing flexors as well as the extensors that were directly injured and provided documentation of the effectiveness of reflexology techniques. I was paid the remaining 32% within 2 weeks of submitting the appeal to the peer review panel.

Insurance companies may have internal quotas regarding claims denials. It is common knowledge that employees are instructed to deny a minimum percentage of claims to ensure reserve funds for the company and to discourage ongoing treatment. Their hope is that the patient or the practitioner will give up on seeking reimbursement. This is particularly true with third-party companies that handle preauthorizations. As a result, you will inevitably come face to face with a reimbursement challenge. The best thing to do is stay on top of unpaid claims and limit the financial risk to your patient and yourself. Follow these guidelines when you find yourself faced with a denied claim for necessary treatment after the service has been provided:

- Identify the cause for the denial.
- Submit a written request outlining your objection to the denial.
- Write a detailed request for reconsideration, including the patient's situation and the benefits of the treatment provided.
- Cite references from the insurance carrier's policy manual to support your case.
- Cite applicable state law (particularly in disputes over scope of practice).
- Request support from the referring HCP and enclose any supportive statements or reports.
- Cite research on the efficacy of the treatment provided.
- Provide photocopies of articles and other documents that may help the claims investigation.
- Cite references from the patient's treatment charts and progress reports, if applicable, to demonstrate the treatment planning and the progress resulting from the treatment.

Select your appeals wisely. Insurance billing often involves an ethical dilemma: When is it the insurance company's responsibility to pay for treatment and when is care the patient's responsibility? When have we finished treating the condition and begun providing palliative or preventative care?

Once you have identified worthy cases, arm yourself with applicable facts, knowledge, and a desire to educate. Take a positive approach and assume the review board has the patient's best interest in mind and simply does not have the information necessary to come to the appropriate conclusion. Provide the board with more information than necessary to reverse the decision. Be honest and thorough and communicate respectfully.

Summary

Insurance billing has its benefits and its risks. Limit the risks by familiarizing yourself with the various types of insurance, by following the billing strategies presented, and by educating yourself on common billing practices specific to your state and profession. Reap the benefits of an increased patient load, a variety of patients offering accelerated learning opportunities, and the satisfaction of influencing the health care community.

Three types of insurance commonly reimburse for massage therapy are as follows:

- Personal injury insurance
- Workers' compensation
- Private health insurance

Each plan has its own billing protocols and reimbursement methods but uses a standard billing form and universal procedure codes and diagnostic codes. All plans require alert claims management and tenacious follow-through to ensure payment. Follow these strategies for successful insurance reimbursement:

- Provide accurate and complete patient documentation and insurance information.
- Stay within designated time limits when providing treatment, billing for services, and appealing claims denials.
- Be prepared to prove medical necessity by obtaining prescriptions for services, documenting patient progress, and providing effective treatment.
- File attorney liens or medical liens on all personal injury cases.
- Maintain accurate payment logs.
- Communicate with insurance representatives professionally, respectfully, and cooperatively.

References

1. Barnes PM, Bloom B, Nahin R. Complementary and alternative medicine use among adults and children: United States, 2007. *CDC Natl Health Stat Report*. 2008;12:1-23.
2. Owens C. *Managed Care Organizations: Practical Implications for Medical Practices and Other Providers*. Los Angeles: Practice Management Information Corp.; 1996.

3. Alliant Plus Health Plan. c22389 CA119202a. Seattle: Group Health Options, Inc.; 2004.
4. Mootz RD. *Advances in Chiropractic.* Vol 4. St. Louis: MosbyYear Book, Inc.; 1997.
5. Mahoney V. *Manipulate Your Future: Insurance Coding and Billing*; 2008. http://shoppingcarts4you.com/massageinsurancebilling/catalog/index.php?cPath=3.
6. http://asirt.org/initiatives/informing-road-users/road-safety-facts/road-crash-statistics. Accessed April 8, 2017.
7. Grigsby B, Rosen S. Some contracts are not worth signing. The Journal: A Publication of the American Massage Therapy Association—Washington Chapter 2000;16 #1:1-6.
8. Adler RH. *Whiplash, Spinal Trauma, and the Personal Injury Case*. Seattle: Adler Giersch PS; 2004.
9. Green MA, Rowell JC. *Health Insurance: A Guide to Billing and Reimbursement*. 9th ed. Clifton Park, NY: Delmar Cengage Learning; 2008.

CHAPTER 9

Ethics

After mastering the concepts in this chapter, the student will be able to:

- Select or create code of ethics to display in practice
- Prepare a draft fee schedule
- Distinguish between wellness and treatment therapy and apply appropriate billing practices accordingly
- Apply good communication skills to discussions with patients regarding expectations and possible outcomes of treatment
- Prepare patients adequately for draping and treatment protocols and practices
- Integrate written consent, both for general care and alterations in standard draping practices and hands-on therapy for sensitive areas
- Integrate privacy and security practices
- Determine ethics and legalities of fee-splitting–type advertising and product sales

After just six additional sessions, Heather can garden, play with her granddaughter, and clean her house. She even joined a co-ed soccer league this summer! She has enjoyed all this activity without acute flare-ups of her chronic lower back pain or trigger lymphedema, a possible concomitant condition postmastectomy. She stretches daily, adding warm-up and cool-down exercises with more strenuous activities, and she stops and rests when her body becomes stiff or achy. She has learned that when she doesn't exercise and rest, the ensuing pain and stiffness limits her activities for several days and her scars limit her range of motion.

If you remember from Chapter 4, Why Document?, Heather had nearly given up on her massage therapist, Wimsey. But after reviewing her SOAP charts, Heather decided to recommit to Wimsey's treatment plan, albeit with alterations. Together, they set and accomplished goals and reviewed clinical and functional progress frequently. Heather's awareness of her body's needs increased, and she learned to identify effective self-care exercises, including self-scar massage, in response to those needs. Heather's healing curve rose dramatically with her renewed commitment and enhanced communication skills.

Now Heather is faced with another dilemma. Her insurance company has notified Wimsey that Heather has reached maximum benefit and coverage is no longer available. Heather feels that care is being terminated prematurely. She is not yet pain free and without ongoing care, she and Wimsey both fear that the symptoms could return.

Heather's insurance policy defines reasonable and necessary care as care provided to correct the presenting condition, bringing it to maximum improvement. The policy clearly states that the therapy for chronic conditions is not covered when the treatment outcome is primarily to maintain the patient's level of function. Maintenance, relaxation, and wellness care are not covered benefits and are the financial responsibility of the patient. Wimsey knows that Heather may never be completely pain free, and she feels that Heather is managing her chronic pain successfully. Should Wimsey support Heather in fighting for coverage until she is pain free, or should she support the insurance company in its decision to discontinue coverage?

Faced with this dilemma, Wimsey reaches out to her peers for support. She invites three fellow manual therapists over for dessert. All share a passion for chocolate, and all have experience with various insurance companies. Wimsey explains her patient's situation (respecting patient confidentiality by not mentioning Heather's name), and the four friends share experiences and opinions. They imagine an ideal world in which the patient's health always takes precedence over profits, and they discuss actions that would best serve the patient's long-term health in the real world.

In the end, they all agree on one thing: the patient is successfully managing her chronic pain, a condition that has plagued her for many years. At this point, it is more important to celebrate the success of the treatments and instill confidence in the patient and in her ability to manage her health than to prove to the insurance company that she still suffers from chronic pain.

Wimsey's friends also agree that now is not the time to withdraw all support. Old habits are easy to fall into. Heather may not be able to afford ongoing care weekly nor does she need that level of care anymore, but monthly treatments for 3 months will maintain progress and monitor any potential flare-ups. It is important for Heather to realize that preventive care is available and affordable. After 3 months of treatments, barring any acute flare-ups, Heather could choose to continue treatments with Wimsey on a monthly or quarterly basis to maintain her progress or to schedule appointments as needed.

Because of their discussion, Wimsey and her friends recognized that they typically treat patients until the prescription runs out or until the insurance benefit is depleted. Preventive health care is the sensible approach; but is it ethical to provide maintenance care when the insurance company clearly states that prevention and maintenance are not covered? Is it ethical to continue care just because the prescription has not been fulfilled or the benefit has not been exhausted? What if the patient has an acute flare-up or suffers from an unrelated trauma later in the year and has no benefits remaining? Together, they agree to consider the question "When is treatment finished?" They want to celebrate when patients accomplish their goals ahead of schedule and educate their patients on the importance of prioritizing regular preventive care in their budgets and on their schedules.

Introduction

Webster's defines ethics as the study of standards of conduct and moral judgment. Ethics comes from the Greek word *ethos*, which means the characteristic and distinguishing attitudes, habits, and beliefs of an individual or a group. By definition, manual therapists are

students of right and wrong, striving to be moral and just and to respect and uphold the standards of the profession.

With few written guidelines and a great desire to be of service, we learn how to conduct ourselves professionally by taking risks. Life is our classroom; our pursuit of excellence provides the lessons. Obstacles that challenge our sense of fairness and test our integrity serve to develop our beliefs and shape our character.

As students, we learn by engaging in debates with our peers, questioning our teachers, and consulting our mentors. Through these activities, our visceral and intellectual understanding of right and wrong expands; and our ability to speak honestly, act without fear and greed, and express compassion without prejudice matures. Eventually, we become role models to others and our learning expands through interactions with those who seek guidance from us.

As health care providers (HCPs), we care deeply for our patients and strive to nurture and heal their bodies and souls. In our efforts to be successful, we are influenced by fears, needs, desires, and spiritual longings. Ethical dilemmas are unavoidable. It is critical that we take steps to encourage personal and professional growth and protect those we intend to serve by setting standards for our business practices, evaluating these practices regularly, and discussing ethical beliefs with others. For example:

- Define your ethical standards. Write them down. If your professional organization has a code of ethics, frame it and hang it in your office. Read it often.
- Create office policies, distribute them to your patients, and stick to them.
- Join a supervision group. If you cannot find one, form your own.
- Evaluate your business practices and professional relationships monthly.
- Invite others to review your business practices annually.
- Establish a relationship with a mentor.
- Mentor others.

This chapter first presents several current ethical dilemmas for manual therapists in the areas of documentation and insurance billing, treatment practices, advertising and relationships with other health care professionals. It then recommends steps for building and maintaining an ethical practice and includes a sample code of ethics, a self-evaluation tool for reviewing your business practices and relationships, and an outline for organizing and participating in supervision groups and mentoring. Be a role model to your peers, patients, and other HCPs.

Ethical issues involving emotional and physical relationships between the practitioner and the patient, such as dual relationships and patient confidentiality, are not discussed in this chapter because of the enormous scope of this subject matter. Many books are dedicated to such topics. A resource list of books on ethical issues in the practitioner–patient relationships is provided in Figure 9-1.

Current Ethical Dilemmas: Billing and Documentation Practices

FEE SCHEDULES

Ethical billing practices include charging reasonable and consistent fees for services provided. It is tempting to charge higher fees to insurance companies because of the time and paperwork required for billing. However, it is unethical and, if proven

FIGURE 9-1. Books on Ethics

1. Allen L. *Nina McIntosh's The Educated Heart: Professional Guidelines for Massage Therapists, Bodyworkers, and Movement Teachers*. 4th ed. Philadelphia: Lippincott Williams & Wilkins; 2016
2. Benjamin BE, Sohnen-Moe C. *The Ethics of Touch*. 2nd ed. Tucson, AZ: SMA Inc.; 2014
3. Giroud B. E*thics and Professionalism for Massage Therapists and Bodyworkers*. New York: Pearson; 2013
4. Taylor K. *The Ethics of Caring: Honoring the Web of Life in Our Professional Healing Relationships*. 2nd ed. Santa Cruz, CA: Handford Mead Publishers; 1995

fraudulent, illegal to charge insurance companies higher rates than you charge patients who do not have insurance coverage, a practice commonly referred to as payer discrimination.

Every patient should be charged the same rate for the same service, regardless of who is paying for the service. Establish fees based on the type of service you provide. For example, it requires more education and experience to provide rehabilitation services for treating specific injuries and illnesses than it does to provide a wellness massage for a healthy person. Make a list of all the therapeutic procedures and modalities you provide—use the CPT® codes to differentiate services—and assign fees accordingly.

Insurance carriers often will refer to the Relative Value Unit (RVU) when establishing fee schedules. Units are calculated taking into account the degree of difficulty of the work (54%), the practice expense (41%), and the malpractice expense (5%). The Resource-Based Relative Value Scale (RBRVS) is available for CPT® codes online at http://www.cms.gov.[1] You may consult the published values for your services, but take into account that codes were written based on a physician's training, overhead, and malpractice risk, and that these are considerably greater than a manual therapist's.[2] Start by researching common practices in your area to determine competitive rates for your services. Consider your level of experience, effectiveness of care, investment in continuing education, quality of supplies, office location, and style of professional dress as you develop your fee schedule—those are all things your patients will be assessing as well.

Once you have established your fee schedule for each service you offer, consider the cost of providing a billing service. It is more costly to delay payment, bill for services, and possibly have a contracted reimbursement rate below your cash rate than to accept payment at the time of service. The issue is whether you provide billing services for the patient, not who is being billed. The billing service costs the same whether you send the bills to the patient or to the insurance company. Therefore, it makes sense to offer a cash discount to all patients who pay at the time services are rendered and to penalize all patients who opt for delaying, regardless of who is responsible for payment. The ethical solution is to offer a modest cash discount as an incentive to patients to pay at the time of service.

What is an ethical discount for payment at the time of service—10%, 20%, or even 50%? Excessive cash discounts are also considered discriminatory and may provoke an audit by the insurance company. Therefore, it is important to be able to justify the discount by comparing it with the actual expense of billing. Billing agencies generally charge

between 7 and 15% of the amount collected. An office providing the service in-house can usually perform the service for slightly more than an outside agency would charge. A discount for payment at the time of service that does not exceed the expense of billing is considered an ethical discount.

Some forms of payer discrimination are considered ethical, such as senior, military, and student discounts, and considerations for financial hardship. List eligibility specifics on your fee schedule, such as income bracket for hardship. Check with a local attorney to make sure that your fee schedule is legal.

Unethical billing practices also arise when services are chosen because they cost more than other equally appropriate services or when a practitioner bills for services that pay higher rates than the services actually performed. This course of action is known as upcoding. Upcoding is tempting when insurance fee schedules delineate different fees for different manual techniques, as though one technique was better than another. For example, HealthCo published a fee schedule that pays $20 per unit for therapeutic massage, $25 per unit for manual therapy, and $28 per unit for energetic therapeutic touch. It is unethical to bill for four units of energetic therapeutic touch if other techniques were also performed. It is also unethical to use only energetic techniques when other techniques would be equally or more effective.

The key to an ethical fee schedule is in its application. Follow these steps to be consistent and not discriminatory.

- Apply the same fee for the same service to everyone, regardless of the type of payer.
- Provide the service that is most appropriate to the patient, regardless of the reimbursement rate for the service.

The consequences of ignoring fee schedule guidelines can be severe. Health care fraud is both a state and federal crime. HIPAA extends the reach of federal fraud and abuse statutes, as well as enforcement, to all private health care plans. In addition to possible civil claims and professional sanctions, you could be facing a federal prosecutor.[3]

TRANSITIONS BETWEEN TREATMENT AND WELLNESS

Sandee's story poses an interesting dilemma concerning when treatment is finished and when maintenance or wellness care begins. A fine line exists between the two, especially when the condition is chronic. If we can identify guidelines for delineating treatment versus wellness care, we can ethically apply those standards to the insurance issue: Who is responsible for paying for care?

The insurance issue is often clouded by our beliefs and experiences. We may believe that insurance policies or case managers too often limit access to manual therapy and prevent patients from receiving the number of treatments necessary to recover from their injuries. Therefore, in the seemingly few situations in which authorized treatment exceeds the number of sessions necessary for healing, we often feel we are justified in continuing to provide care. Certainly, the patients are willing to continue. After all, manual therapy is effective, the relationship between the therapist and the patient is supportive, and it feels good. Continuing treatment makes sense because, of course, an ounce of prevention is worth a pound of cure.

According to standard insurance definitions, treatment is warranted until the condition is corrected or maximum functional improvement is made. These definitions also state that treatment must provide the patient with appropriate instruction for follow-up,

self-care, and prevention of future occurrences. All maintenance and wellness care are the financial responsibility of the patient unless otherwise specified by the insurance plan. Given those parameters, how do we determine when treatment ends and maintenance care begins?

Sometimes, it becomes obvious when the patient has reached maximum healing. He or she is pain free and fully functional. At other times, as with chronic pain, things are not so clear. In such cases, wellness is determined by the patient's ability to manage pain and successfully modify activities. The focus is not on living pain free, but on the patient's quality of life—the ability to participate in everyday activities. Use the following guidelines to determine when treatments are no longer necessary for resolving the patient's condition:

- The patient is able to function normally or there is no functional progress for a period of time (as defined by the insurance company).
- The patient has no significant symptomology or clinical progress has peaked.
- The patient demonstrates self-awareness by identifying situations, activities, or emotions that exacerbate his or her condition. The patient implements self-care strategies to limit exacerbations and to remedy the exacerbations when they do occur.

Test your findings by discontinuing care for a predetermined length of time. If, for example, after 4 weeks without treatment, Darnel is sufficiently symptom free and active, care can be reduced to a monthly (or maintenance) level of care. If Darnel experiences an exacerbation or acceleration of the condition, regardless of performing his self-care routines, ongoing treatment is warranted.

Most patients who reach maximum improvement for their conditions would benefit from wellness care. Encourage the patient to return monthly for wellness care for 3 months after terminating treatment. During that time, provide care as needed and fine-tune the patient's self-care instructions. If his or her health deteriorates without regular care, you have a case for the reinstatement of insurance coverage. If the patient is able to administer appropriate self-care and maintain his health status, celebrate his accomplishments and invite him to continue participating in monthly or quarterly wellness sessions, or you can refer him to someone who specializes in wellness care.

PREFERRED PROVIDER STATUS

Insurance carriers contract with HCPs with the intent of limiting the health care services provided and the amount they reimburse for those services. The carriers either contract with providers directly or purchase provider contracts through an insurance network. The insurance carrier then provides incentives to motivate insureds to seek health care services from preferred providers. Incentives may include reduced copays or waived deductibles.

Insurance networks and insurance carriers can support only a limited number of providers. Set numbers of providers are credentialed for a given area based on the number of insureds or lives that reside in that area. As the number of covered lives changes in a given area, the network or panel may open up to new providers until the ratio of lives to providers is considered adequate.

Only credentialed manual therapists are permitted to bill under the preferred provider contract. It is unethical and often illegal for noncredentialed practitioners to bill for services under the license of the credentialed provider.

TALES FROM EXPERIENCE

One Preferred Provider in a Clinic of Many

Rosie owns a manual therapy clinic in a bustling urban setting. The trendy neighborhood has a reputation for being health conscious, and it boasts a well-worn walking trail, several juice bars and cafés, a health club, day spas, and wellness centers. Rosie is an excellent practitioner, and her services are in high demand. She has added a dozen other manual therapists to her staff over the years to meet the demand. She and her staff receive referrals from the various HCPs in the area, as well as walk-in traffic.

A large insurance network provides manual therapy contracts to most insurance carriers in the area. Rosie was able to get on the preferred provider list several years ago. Because the neighborhood is densely populated with manual therapists, it has become difficult to get new providers credentialed. Rosie is the only practitioner in her clinic with preferred provider status. As a result, she has had to refer her steady cash-paying patients to her staff so that she can accommodate the large number of insurance patients referred to the clinic.

Rosie and her regular patients are upset at the turn of events. Rosie wants to be able to see her cash-paying patients, and her regulars miss her care. She decides to have her staff treat the insurance patients, and she signs the charts and bills under her name. They are her employees, after all—this must be permissible. She promises to check it out with the insurance network, but she never gets around to it.

During a random audit, the insurance company uncovers Rosie's fraudulent billing practices. Company policy states that only the credentialed provider may deliver the health care services unless the provider is on vacation and notifies the company in advance of the dates during which her staff will be taking over her patients. As a result, her provider status is revoked and her staff is barred from contracting with the company as preferred providers. In addition, the company filed a complaint with the state regulatory body requesting disciplinary action against all practitioners involved.

Clinics can apply for credentialed status as an entity, but each individual provider within the clinic must go through the review and application process. Regardless of the number of employees versus credentialed providers, the clinic acquires its own UBI number to use for billing. The insurance company pays the clinic and the money is dispersed to the individual therapists through their paychecks. As employees come and go, they each become credentialed without disrupting the clinic's status; the non-credentialed providers will simply not be able to treat patients under that number until the application process is complete.

TALES FROM EXPERIENCE

Consequences of Fraudulent Billing

Two stories of fraudulent billing have been told in previous chapters: the chiropractors who served time in a federal penitentiary when found guilty of billing for treating family members, and the massage therapist whose treatment notes did not reflect the services billed (upcoding) and had to repay thousands of dollars. The previous tale told of a third case: the massage therapist who billed for her employees' services under her preferred provider account and lost her preferred provider status.

Fraudulent billing is ruinous. Don't do it. It's not worth it.

TIPPING

Many manual therapy disciplines, such as massage therapy, are more accustomed to a cash clientele than the insurance reimbursement style of payment typical of physical therapy practices. Tipping is a practice that often accompanies cash practices, especially in spa environments. Given this historical experience, patients may be confused about tipping. They don't tip their other health care practitioners, but they have tipped massage therapists in the past, so what is the expectation when receiving massage therapy to treat health conditions?

There is no easy answer for this ethical, or at times legal, dilemma. The most important thing is to research any legal conflicts, create a policy, and share it with your patients in advance so that there is no confusion.

We may also be conflicted about tipping. One possible conflict comes with the desire to differentiate between wellness and treatment therapy. All manual therapy has health benefits, but you may spend more time and money getting trained to treat cancer, whiplash, or neurologic conditions, for example. Wellness sessions may be more routine, and treatment care requires more time doing evaluations and charting, in addition to the more complex treatment plans. As a result, you may choose to charge more for treatment care than you charge for wellness sessions to mitigate, in part, the lack of tipping. Understandably, with insurance reimbursement dipping below cash prices, you may be motivated to accept, even encourage, tips.

There are also legal considerations that may influence your decision to accept tips when billing insurance. The contract you signed with the insurance company may stipulate that you must accept the contracted reimbursement amount as payment in full. For example, many workers' compensation contracts specifically state that accepting money beyond the contracted amount is not allowable. If you have any questions about your interpretation of the contract, call each insurance company that you are contracted with and verify the intent. Ask clearly and directly, "If a patient wants to tip me for my services, may I accept the money? Does it in any way invalidate our contract?" From there you can develop policies that accommodate each scenario, wellness and treatment care, and if necessary, tailor policies to each insurance company. Then you will feel comfortable and confident, and so will your patients.

TIMELY DOCUMENTATION

Unethical charting practices occur when a patient's chart is filled in weeks, months, or years later because of a request for charts, payment has been denied, or rebilling requires copies of all treatment notes. Charting should be done in a timely fashion. It is difficult

to remember a particular session after several other sessions have blurred the details. The best time to chart is during or immediately after the session. Everyone has days, however, when the charts pile up and notes are not taken until the next morning. It is stressful but possible to recreate the session 24 hours later. However, few (if any) of us can record a session accurately days or weeks later. Electronic charting automatically records the date the session note was created. This cannot be modified, preventing mistakes and verifying when the record was initiated.

TALES FROM EXPERIENCE

Carbon-Dating?

At a billing seminar, an attorney told a story of a chiropractor whose notes were carbon-dated—a test that establishes the time frame of a record. His patient had been injured in a car accident, and the attorney for the at-fault party suspected tampering with the treatment notes, so he ordered the tests. Test results showed that the HCP had filled in the chart notes 2–3 years after the treatments had been provided. The patient's case was adversely affected.

TWO SETS OF NOTES

Health records are confidential and must be kept secure. At the same time, they need to be completely accessible to the patient and to other members of the health care team. Electronic health records (EHRs) have made great strides in bridging the communication gap among providers, and between providers and patients. Sylvia Mathews Burwell from HHS touts EHR adoption as a top administrative achievement, allowing providers to work together to create coherent care experiences, and giving patients access to their medical records to use as they need.[4] Many EHRs provide a secure patient portal, and patients can access their health records from any Web-connected device.

With EHR adoption, the charts we keep are now more transparent than we have been accustomed to in the past. This may feel uncomfortable at first but is technically not different than keeping paper files. As always, when requested or subpoenaed with the proper authorization from the patient, the entire file is discoverable. Keeping a second set of notes for your eyes only, or using sticky notes as reminders of personal things that are removed when making copies of paper files, is unethical and often considered illegal. Every bit of patient information is discoverable when a file is requested. Keep all necessary information in the patient's health record.

Current Ethical Dilemmas: Treatment Practices

TREATMENT EXPECTATIONS

At times, patients form expectations of their therapist based on hearsay. Patients' healing time and abilities vary in many ways, including condition, environment, health history, genetics, emotional complications, daily physical demands, and the like. As the therapist, we may or may not be able to live up to the stories our patients have been told by their friends and family. It is critical to represent our abilities honestly and refrain from committing to specific results or time limits for healing.

TALES FROM EXPERIENCE

Promises, Promises

Annie experienced what anyone would call a miraculous recovery. She had a long history of head and neck trauma, and after a summer of painting the exterior of her house and working long hours at the computer, she ruptured a disk in her neck. The pain was so intense that she could not lift her head high enough to gaze across the horizon, nor could she hold her head up long enough to eat at the dinner table. The numbness and weakness in her right arm was so great that she could not butter her toast or brush her teeth.

Annie's doctor scheduled an MRI. In the meantime, Annie began seeing her Feldenkrais practitioner, John. The first few visits were house calls because riding in a car was excruciating for Annie—she had to hold her head in her hands and apply traction so the bumps in the road wouldn't cause more pain than necessary. By the time the results of the MRI came back and the neurosurgeon met with Annie to discuss treatment options, she was pain free, driving to her own appointments and working part-time. One month from the date of injury, she was working full time and had full mobility in her neck.

John's phone started ringing off the hook. Annie worked in health care and her peers, amazed by Annie's progress, began referring their patients, friends, and family members to John. But not everyone responded to John's care as Annie had, and several were disappointed when they were not symptom-free in 2 weeks.

Annie took care of herself in more ways than John knew and in more ways than she told her peers at the clinic. She took naps after every session, limited her activities, and received acupuncture, Tui Na, Polarity, and lymph drainage. She practiced mindfulness meditation and Qi Gong daily. She began her treatment immediately and aggressively after her injury, getting daily care for the first week and three times a week for the following 3 weeks. She had the resources and knowledge to seek treatment that was effective for her, whether it was prescribed by her doctor or covered by her insurance. Annie was willing to do whatever it took to get well; she acted quickly and she never lost sight of her belief that she could heal completely.

John is a brilliant practitioner. He serves all patients equally to the best of his abilities, given each patient's unique situation. The only thing lacking in his sessions has been the conversation about each person's unique healing cycle: he neglected to address the patient's expectations and their ability to participate between sessions. He, too, had been carried away by his success with Annie. This experience not only increased his skills for working with disk injuries, but also reminded him of the need to communicate clearly with his patients; that is, to hear their expectations and cautiously discuss possible outcomes based on individual circumstances without making promises he couldn't keep.

Many factors influence healing. As HCPs, we can only attempt to find the right combination of therapeutic procedures and modalities, communication techniques, and referrals for each patient. Don't take it on yourself to meet the expectations of everyone who comes to you for help. Instead, talk with them, find out about their expectations, tell them what you can honestly predict—which is often nothing more than possibilities—and ask for their help in discovering the best treatment plan.

Educate yourself on the state regulations for your profession. Know what claims are legal for your scope. For example, in New York, claims regarding the benefits of massage therapy must be qualified with a statement that massage therapy "may" reduce inflammation, or "may" improve range of motion. The only concrete claim permissible is that massage therapy increases circulation.

SCOPE OF PRACTICE

Manual therapy encompasses many professions and techniques. Much cross-training occurs, often without the knowledge of the licensing laws for each profession in each state. A workshop on a manual technique may be taught by an osteopath and may include chiropractors, nurses, physical therapists, dentists, and massage therapists as students. Remember that you may be taught techniques that are outside your scope of practice. Receiving training in a technique does not automatically license you to perform it in your practice.

TALES FROM EXPERIENCE

Do the Right Thing

Leisha is a massage therapist in Oregon. To escape the cold winter rains, she travels to Hawaii every January for Lomilomi training in the home of an elder Lomi master. Leisha lives there for 4 weeks every year and adheres to a rigorous schedule of fasting, taking cleansing herbs, and giving and receiving treatments. She learns to harvest the herbs, make cleansing tonics, perform thrust adjustments on the extremities, and apply vigorous manual techniques to increase the circulation. After 4 years of training, she received the blessing of the elder to provide this healing ritual to others.

Leisha is confident of her skills but knows that Oregon law does not permit her to perform joint manipulations with a thrusting force. Several months go by without temptation. Then, one day, Leisha treats a 40-year-old woman with gnarled, stiff, and painful toes. Leisha knows that the joint manipulations she learned in her Lomi training would benefit this woman, who is prematurely losing mobility in her toes and feet. What should she do?

If the laws that dictate your profession's scope of practice do not adequately represent the skill and training of those licensed, then work to update the laws. Until the laws change, resist the temptation to provide services outside your scope. Create a list of practitioners who can provide those services and refer out when necessary.

THERAPEUTIC INTENT: CHARTING DRAPING, BREAST MASSAGE, AND THE PELVIC FLOOR

Clear communication and documentation can make all the difference between a patient feeling uncomfortable, wondering if a boundary was crossed, and feeling confident in the therapeutic value of a session.

Many complaints to State Boards are against legitimate manual therapists with no sexual malintent. Issues arise when therapists assume every patient knows the importance of working on the gluteals or pectoralis muscles, for example. Undraping to massage the hips is second nature to a manual therapist, but many patients have never had a stranger see that part of their body or been touched there by anyone outside of their immediate family. To ensure patient comfort, have a conversation before the client is on the table and feeling vulnerable. Often, patients are lulled into a sense of relaxation and are in a semi-trancelike state during a session. It is not until the hip massage is under way that the alarms start going off and doubt arises, and the patient begins to doubt whether this is appropriate. They leave confused, and after sharing their experience with a spouse or friends, they get angry and file a complaint.

Go beyond a simple Consent to Treat section on an intake form and discuss your draping protocol and the therapeutic intent behind your treatment plan. Ask for a separate written consent once they are informed of the therapeutic intent behind treating sensitive areas. A separate Consent to Treat form is important when performing breast massage or pelvic floor and perineal work. Document any alterations in your standard draping protocol in your session note, and the therapeutic intent behind performing manual therapy on the breasts or pelvic floor area. Be purposeful and never expose or touch any genitalia.

In addition, obtain specialized training in manual therapy for sensitive areas. Seek additional education whenever offering breast massage or pelvic floor work, for example, and have your certificates visible. Ensure patients feel comfortable and confident in your work by communicating, documenting, and demonstrating professionalism, and curb the number of complaints submitted against well-intended manual therapists.

Current Ethical Dilemmas: The Health Care Team

COMMUNICATING WITH REFERRING HEALTH CARE PROVIDERS

As health care is currently structured, physicians and possibly naturopaths or chiropractors (depending on the insurance policy and the state regulations) are considered primary HCPs. It is the primary HCP's responsibility to diagnose the patient's problem, orchestrate treatment, and refer to adjunctive therapists, such as massage therapists.

Many of our patients are self-referred, and their HCP may or may not know they are receiving massage therapy. It is imperative to receive permission from patients before communicating with their HCP to avoid any embarrassment or conflict between them and their HCP. If you are working under the direction of the referring HCP but not under his or her supervision, good communication is required. In either case, provide the HCP with clear, complete information so that he or she can give the patient the best possible treatment.

Occasionally, you may find yourself disagreeing with the referring HCP about a patient's condition or treatment. Do not express this disagreement to the patient. Instead, state your views to the referring HCP—calmly, professionally, and tactfully—with all the supporting evidence you can provide. If your input is not considered or if you find that you can't endorse the prescribed treatment, your best choice may be to withdraw from the case. However you choose to handle the situation, remember that the referring HCP is the final authority and that it is unethical for the manual therapist to undermine the relationship

between the referring HCP and the patient. If the patient approaches you with complaints about the referring HCP's approach to the treatment plan, support the patient in addressing the issues directly with the referring HCP.

PRIVACY: CONFIDENTIALITY AND CONSULTS

The health information form contains a request for permission to exchange information with the other members of the patient's health care team. In many cases, practitioners do not need the patient's consent to speak with referring providers—state and federal health care privacy laws permit open communication between referring HCPs. Regardless, it is a good idea to inform the patient that information will be shared and with whom it will be shared. HIPAA privacy rules make good sense for all HCPs and their patients (see online, Appendix B for blank forms) regardless of whether HIPAA applies to your practice. An authorization for releasing protected health information is valid and meets HIPAA regulations when it contains the following core requirements:

- A description of the information to be disclosed
- The name of the person authorized to make the disclosure
- The name of the person to whom the disclosure may be made
- A description of each purpose of the requested disclosure, such as "at the request of the individual" when an individual initiated the authorization
- An expiration date or event for the authorization as it relates to the individual or the purpose of the disclosure
- Signature of the authorizing individual and the date of signing
- Statement about the right of the individual to refuse to sign the authorization and to revoke any authorization given in writing and a brief explanation of how to do so
- The potential for information disclosed under the authorization to be re-disclosed by the recipient and no longer protected by the act
- The authorization must be written in plain language[5]

When providing information to other practitioners, respect the patient's confidentiality and limit those conversations to information pertinent to the patient's condition. Omit your personal opinions about the patient and any gossip or details that have no bearing on the case. Refrain from discussing patient cases in public, where others who are not bound by HIPAA confidentiality regulations might overhear sensitive information. Follow the guidelines for protecting patient's health information detailed in Chapter 5, Documentation: Intake Forms, regardless of your status with HIPAA compliance. Your patients will appreciate it.

The use of EHRs makes consults with other providers easier. Sharing handwritten notes are not acceptable ways to communicate, instead should be translated into computer-generated reports. EHRs can sort and condense session notes, making them easy to read and understand (see Figure 9-2). Reports can be generated with the click of a few buttons. Simply insert a brief summary into the computer-generated information and dramatically reduce the time spent writing reports from scratch (see Figure 9-3). These can be electronically sent using an encrypted e-mail server.

When using an EHR, make sure your devices are password protected. Set your screen to go to sleep when not in use, and save and log off frequently. Lock your data before giving patients access to their files. Train any staff on your privacy policies, and ensure no patient has access to other patient's files.

The following are specific instances of privacy violations that occur all too frequently. Remember, it is important to practice confidentiality in all your communications.

- Never reveal the name of your patients when sharing stories with colleagues, even if you have the patient's verbal permission to do so. Many names of famous patients are dropped in casual conversations. If you insist on telling stories and naming names, get it in writing. The patient should sign off on what you will be able to say about them and in what context.
- Never share health information of one patient with the patient immediately following. They might be walking with a cane or sporting a new cast, and the patient's paths may

FIGURE 9-2. Electronic Health Record (EHR) Session Notes

Session Information
Heather Pratt
Date of Birth: 9/8/1977

Massage Therapist: Diana Thompson

Service Date: 5/13/2017

Presession Information

Stress Scale: 5
Surgery scars have limited my mobility and I am limited to lifting 10 pounds. I cannot lift my 8-month-old daughter and she and I both are quite upset about it.

Pain Scale: 3
The pain is improving.

Activity Scale: 6
I still can't lift my arms overhead, making it difficult to wash my hair and get dressed/undressed. I can't lift my daughter to hold her, or get her in and out of the car.

Health Status:

Treatment

Duration: 60 minutes

Client Complaints
Pain still with lifting daughter and raising arms overhead to dress. Doesn't feel so groggy any more, and pain is better since last massage. Wants more work on scars.

Assessments/Findings
Adhesions R>L from chest scars to ribs. Puckering at medial ends BL. Swelling under the R scar and near axilla on the left scar.

Treatment Position/Location
Supine, focus on chest. Briefly applied MLD to neck, chest, axilla, and abdomen

Treatment Techniques
Scar massage, MLD

Additional Notes
Continue to do self-MLD and scar massage daily, within comfort. Use dry brushing for self-MLD.

Postsession Information

Stress Scale: 3

Pain Scale: 2

Activity Scale: 7

Feedback/Comments
Much more relaxed and feeling more confident in progress. Pain is less and able to lift arms overhead more easily when dressing after massage.

cross each week, but do not answer their questions about what happened. Patients can ask questions of each other regarding their health when in the waiting room.

- Always file the previous patient's chart before the next patient arrives. Do not leave the patient in the room with other patient's charts lying about.
- Do not leave specific health information on a phone's messaging system without written permission to do so.
- When a patient gives a gift of massage to a friend or family member, it is not appropriate to tell them that the gift certificate was used. Thank them for trusting in your services enough to buy the certificate for a loved one and leave it at that.

FIGURE 9-3. Electronic Health Record (EHR)—Build a Report

-Hide Health Info

Health Info

Knee pain, foot pain, both worse in past year

-Hide Health History

Health History

MVC 2014, Dx severe herniation L-4/5, four knee surgeries over past 20 years, high blood pressure, on statin and supplements, competitive athlete since school through 40s.

-Hide Report Summary

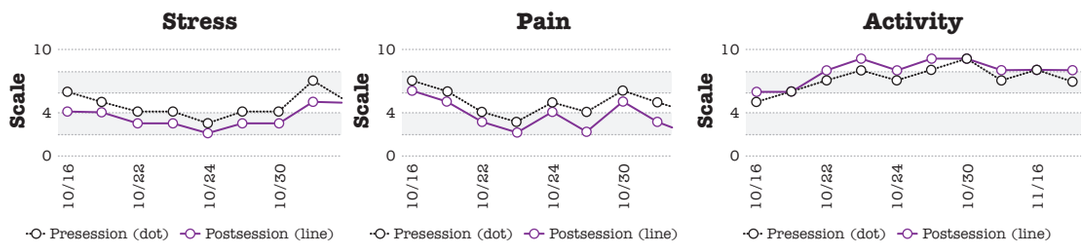
Report Summary

Edit

Ms Phillips presented with bilateral knee and foot that prevented many activities, limiting walking, climbing up and down stairs, and weightbearing exercise. With regular massage therapy, an anti-inflammatory diet, and a cautious increase in exercise, Ms Phillips can now ride an elliptical for 15 minutes, and can walk around the track for one mile without increased pain.

-Hide Progress Graphs

Progress



-Hide Session History

Session History

From Any To Any

Filter

Date	Presession Scales			Treatment Notes	Postsession Scales		
	Stress	Pain	Activity		Stress	Pain	Activity
4/18/2017	3	3	7	Completed	2	1	8
11/16/2016	5	4	8	Completed	5	2	8

PAYMENT FOR REFERRALS

As HCPs, we are responsible for serving the patient to the best of our ability. Accepting payment for referrals can cloud that ability and compromise our ethics. In all cases, this creates a conflict of interest. In many cases, it is illegal. State and federal laws prohibit HCPs from splitting fees or exchanging anything of value for health care services or referrals.[6] The practice of accepting payment for referrals, or referring to clinics or laboratories in which the provider has a financial interest, is known as rebating or "kickbacks." Severe penalties can be placed on practitioners who violate laws of this nature.

It is appropriate to refer within a health system network or preferred provider list. It is not appropriate when the referral is based on the prospect of financial gain.

TALES FROM EXPERIENCE

Who Is Best for the Patient?

Helena's office is centrally located in town. As a result, several HCPs from around the area refer patients to her. One chiropractor on the north end has expanded his office and needs more patients to meet his expenses. He offers Helena $25 for every patient she refers to him. Typically, Helena provides a list of chiropractors to patients in need of chiropractic services and highlights those who are located conveniently for the patient and who specialize in the area of need. After the chiropractor's offer, Helena begins passing out his card to every patient, regardless of which end of town they live and work in or what their special needs for care are. Is Helena acting in an ethical manner, keeping the best interests of her patients in mind? Are the two of them breaking rebating laws?

ADVERTISING AND ANTI-KICKBACK LAWS

There has been considerable debate over the ethics and legalities of advertising Web sites such as Groupon and LivingSocial that offer health care services. Although laws have existed for some time now about rebating, states are beginning to create laws specifically for defining practices for Web-based advertising that go beyond set fees. The simple act of taking a percentage of a health care service versus a set fee, previously the standard for advertising, pushes it into the realm of fee-splitting. Because the advertising firm receives a percentage of a service, it can be perceived as splitting fees for a referral and pushing a service that may not be appropriate for a patient.

A New York statute, for example, prohibits soliciting patients using a third party, calling it unprofessional conduct.[7] Oregon has completely banned dentists and chiropractors from offering health care services on Groupon-style discounts because of fee-splitting as of 2014.[8] California was the first state to permit HCPs to advertise using online vouchers for specific services, beginning in 2017, with specific requirements: consultations are required to ensure treatment is appropriate, full refunds must be provided if the patient is not a candidate, and basic health care services cannot be offered, only elective or cosmetic procedures.

Before using this type of marketing, consider the following:

- Check state/provincial laws for rulings on discount Web sites that split fees rather than have a set advertising fee for health care services.
- Check with an attorney who specializes in health care law and ethics violations.

- Know that federal kickback laws will likely kick in if you take Medicare or Medicaid, bill veteran's benefits, or receive insurance reimbursement for services that are medically necessary, unless you are offering services that are not covered benefits under any of those plans.
- Consider if coupons are in line with your brand. Will you attract the type of patient/clients you desire?

PRODUCT SALES

Manual therapy is a profession where the number of patients you can see in a day or week is limited, a number that often decreases as we age. In an attempt to increase our income, rather than have it decline over time, we often look to product sales. There are a few ethical considerations before initiating or expanding your product offerings.

Scope of practice may dictate what you can sell. For example, it may be illegal in your state or province to prescribe over-the-counter supplements. If this is the case, selling supplements could be construed as endorsing or prescribing, and therefore would be unethical for you to sell in your clinic. Be careful about selling anything taken orally, and stick to things that you are permitted to use in your sessions.

Many products require proper training to use safely and effectively. Sell products that you are fully trained to use, and be sure to train your patients to use them safely. Aroma therapy, for example, may be more harmful than you might expect. There might be harmful interactions with medications, or when combined with other products. I recently worked on a scar that became permanently red and raised after an Epsom salt bath, a seemingly harmless self-care technique. Perhaps it was in combination with an essential oil? It was too long ago for them to remember. Know the contraindications and cautions for each product.

Make sure not to sell products while the patient is on the table. Patients can be particularly vulnerable when on the table in a trance-like state, or when you are in a perceived position of authority. Use the product in the session, wait until the patient is dressed, and promote only products that are appropriate for the patient's lifestyle and condition.

Consider if selling a product will negatively affect your referrals. Your reputation with referring HCPs is influenced by your skill, work environment, and the products you sell.

Be clear about your intent to sell. Access to self-care tools is beneficial for both the therapist and the patient; having a "cash cow" product that is primarily for your benefit is questionable.

RESEARCH ETHICS*

In Chapter 10, Researching and Writing Case Reports, guidelines are presented for protecting patient information. Beyond the ethical norms for privacy in research, there are norms that promote truth in research, values essential to collaborative work, norms that ensure the researchers can be held accountable to the public, and other moral and social values regarding social responsibility and human and animal rights. Following is a general summary of some principles that various codes of ethics for research include[9]:

- Honesty: Strive for honesty in all scientific communications. Honestly report data, results, methods and procedures, and publication status. Do not fabricate, falsify, or misrepresent data. Do not deceive colleagues, granting agencies, or the public.

*This excerpt is adapted from https://www.niehs.nih.gov/research/resources/bioethics/whatis/index.cfm

- Objectivity: Strive to avoid bias in experimental design, data analysis, data interpretation, peer review, personnel decisions, grant writing, expert testimony, and other aspects of research where objectivity is expected or required. Avoid or minimize bias or self-deception. Disclose personal or financial interests that may affect research.
- Integrity: Keep your promises and agreements; act with sincerity; strive for consistency of thought and action.
- Carefulness: Avoid careless errors and negligence; carefully and critically examine your own work and the work of your peers. Keep good records of research activities, such as data collection, research design, and correspondence with agencies or journals.
- Openness: Share data, results, ideas, tools, resources. Be open to criticism and new ideas.
- Respect for intellectual property: Honor patents, copyrights, and other forms of intellectual property. Do not use unpublished data, methods, or results without permission. Give credit where credit is due. Give proper acknowledgment or credit for all contributions to research. Never plagiarize.
- Confidentiality: Protect confidential communications, such as papers or grants submitted for publication, personnel records, trade or military secrets, and patient records.
- Responsible publication: Publish to advance research and scholarship, not to advance just your own career. Avoid wasteful and duplicative publication.
- Responsible mentoring: Help to educate, mentor, and advise students. Promote their welfare and allow them to make their own decisions.
- Respect for colleagues: Respect your colleagues and treat them fairly.
- Social responsibility: Strive to promote social good and prevent or mitigate social harms through research, public education, and advocacy.
- Nondiscrimination: Avoid discrimination against colleagues or students on the basis of sex, race, ethnicity, or other factors that are not related to their scientific competence and integrity.
- Competence: Maintain and improve your own professional competence and expertise through lifelong education and learning; take steps to promote competence in science as a whole.
- Legality: Know and obey relevant laws and institutional and governmental policies.
- Animal care: Show proper respect and care for animals when using them in research. Do not conduct unnecessary or poorly designed animal experiments.
- Human subjects protection: When conducting research on human subjects, minimize harms and risks and maximize benefits; respect human dignity, privacy, and autonomy; take special precautions with vulnerable populations; and strive to distribute the benefits and burdens of research fairly.

Steps Toward an Ethical Practice

CODE OF ETHICS

Hang your code of ethics in your office. This code should be one you strive to abide by—one that reflects your beliefs and professional behavior. Many professional organizations have a code of ethics and a disciplinary body to enforce it. Displaying ethical standards instills confidence in patients that their practitioner cares for them, observes a high standard of behavior, and is accountable for his or her actions.

FROM THE LITERATURE

Code of Ethics

This Code of Ethics is a summary statement of the standards of conduct that define ethical behavior for the massage therapist. Adherence to the code is a prerequisite for admission to and continued membership in the American Massage Therapy Association (AMTA).

Principles of Ethics: The Principles of Ethics form the first part of the Code of Ethics. They are aspirational and inspirational model standards of exemplary professional conduct for all members of the association. These principles should not be regarded as limitations or restrictions, but as goals for which members should constantly strive.

Massage therapists/practitioners shall:

1. **Demonstrate commitment to provide the highest quality massage therapy/bodywork to those who seek their professional service.**
2. **Acknowledge the inherent worth and individuality of each person by not discriminating or behaving in any prejudicial manner with clients and/or colleagues.**
3. **Demonstrate professional excellence through regular self-assessment of strengths, limitations, and effectiveness by continued education and training.**
4. **Acknowledge the confidential nature of the professional relationship with clients and respect each client's right to privacy within the constraints of the law.**
5. **Project a professional image and uphold the highest standards of professionalism.**
6. **Accept responsibility to do no harm to the physical, mental, and emotional well-being of self, clients, and associates.**

Rules of Ethics: The Rules of Ethics are mandatory and direct specific standards of minimally acceptable professional conduct for all members of the association. The Rules of Ethics are enforceable for all association members, and any member who violates this code shall be subject to disciplinary action. Massage therapists/practitioners shall:

1. **Conduct all business and professional activities within their scope of practice and all applicable legal and regulatory requirements.**
2. **Refrain from engaging in any sexual conduct or sexual activities involving their clients in the course of a massage therapy session.**
3. **Be truthful in advertising and marketing, and refrain from misrepresenting his or her services, charges for services, credentials, training, experience, ability, or results.**
4. **Refrain from using AMTA membership, including the AMTA name, logo or other intellectual property, or the member's position, in any way that is unauthorized, improper, or misleading.**
5. **Refrain from engaging in any activity which would violate confidentiality commitments and/or proprietary rights of AMTA or any other person or organization.**

SELF-EVALUATIONS AND PEER EVALUATIONS

Take time to review your business practices and professional relationships. Regular self-evaluations help identify and resolve difficult situations before problems arise. When you open a new business, establish office policies and a fee schedule, list your services and office hours, and provide copies to all patients. Setting clear boundaries and business parameters helps you treat all patients fairly and equally and provides a comfortable working environment for you and your patients. Review your business guidelines monthly and keep them current. Patients become confused and frustrated when they are given policies that no longer apply or are no longer enforced.

As part of your monthly self-evaluation, take 10 minutes to consider a few questions. If your answers to them highlight a problem situation or motivate a call to action, describe the specific situation in writing. Clarify your role in the situation honestly and compassionately. Seek counsel from your peers when necessary. Identify possible actions and consider the consequences. Determine the timeline for the appropriate action, and then follow through.[10]

- Did I conduct myself ethically and legally in all my professional affairs?
- Did I maintain the confidentiality of my patients?
- Did I maintain good boundaries with my patients?
- Was I uncomfortable enforcing any office policies? If so, did the situation warrant flexibility, or did fear dictate my decision to bend a policy?
- What are my strengths and limitations? What action can I take to improve?
- What steps have I taken to ensure my well-being?
- Are there any issues on which I should seek counsel from my peers?

Annually, review your fee schedule, office policies, and business practices with a peer or a mentor. Review your billing and accounting practices with a professional. Implement changes when appropriate.

CONSULTATION GROUPS

Consultation groups, also known as peer supervision or co-vision groups, consist of people who have a common interest who meet regularly to share ideas, solve problems, and build a community. Common interests may be as broad as manual therapy or as specific as therapists who treat cancer patients.

Individuals join consultation groups to get support and information, to form professional relationships, and to gain skills. Not only do the people who participate in the consultation groups benefit from the results, but so do their patients, the community, and the profession as well. Ethics are difficult to learn out of a book. They must be experienced, experimented with, discussed, and hotly debated. By participating in consultation groups, we can study ethical dilemmas from a variety of perspectives and differing levels of experience, sorting out the possible consequences before our patients can be harmed by our actions. The group members hold one another accountable for telling the truth, express compassion and respect for all involved, and offer advice about difficult or confusing issues.[10] Follow these guidelines for establishing a consultation group in your area:

- Define goals for establishing a group.
- Identify parameters, including how many people to involve, how often to meet, length of the meetings, and such.
- Create a list of individuals who have similar goals or needs for a group.

- Check the list for individuals you respect and from whom you can learn. It is important to include not only those who share similar opinions but also people who can offer diversity to the group.
- Contact those on your list and gauge their interest. Ask if anyone is willing to help you launch the group.
- Select a date for the first meeting. Explain your vision for the group with those on your list and invite them to join you. If you are lacking in numbers, ask those who are interested in being part of the group to invite others who may also share the same vision.
- At the first meeting:
  - Confirm the dates, locations, and times of the meetings. If it is important to the cohesiveness of the group, get a commitment from everyone to attend four consecutive meetings.
  - Clarify the goals of the group.
  - Identify the topics to be covered in the first few meetings.
  - Find out whether a mediator, provocateur, or educator is desired for any of the meetings.
  - Decide whether you want to rotate responsibilities, such as hosting, providing snacks, facilitating the discussion, and monitoring the time.
  - Identify guidelines for group interaction, such as maintaining one another's confidentiality, communicating with respect, and speaking honestly.
  - Identify guiding principles that suggest ethical behavior without mandating specific rules.
- For information on identifying guidelines for such occasions, Margaret Wheatly offers guiding principles in her book, *Leadership and the New Science: Take Care of Yourself, Take Care of Each Other, and Take Care of This Place.*[11] Kylea Taylor, in *The Ethics of Caring*, defines ethical behavior as reverence for life demonstrated by right relationship and offers Buddha's concepts for right relationship: What I do affects you, what you do affects me, and what I do to you ultimately affects me.[12]
- At the end of the meeting, evaluate the outcome. Did you meet your goals? Did you have fun? Make adjustments when necessary to ensure the success of future meetings.

TALES FROM EXPERIENCE

A Call to Action

Barb works for a natural foods grocery chain that provides seated massage to customers. There are five stores in her town, and each store employs four to five manual therapists. Barb discovers that providing massage in front of the checkout lines in a grocery store presents problems that she never had to deal with in her private practice, such as maintaining confidentiality. She can tell that her coworkers are also struggling with the same issues, but she knows it is not appropriate to discuss them at work. She decides to call the practitioners from the stores and try to stir up interest in meeting together and helping one another with the problems inherent in the work environment.

Barb finds 10 people interested in meeting. She secures a meeting room at the community center and invites one of her teachers from massage school to facilitate the group discussion. She asks a few people to bring snacks and drinks and someone else to make confirmation calls.

(Continued)

TALES FROM EXPERIENCE (*Continued*)

A Call to Action

Eight of the twenty-three massage employees attend the meeting. Barb welcomes everyone and introduces the facilitator. The facilitator leads the group in defining the goals for the meeting and identifying topics for discussion. She suggests some guidelines and creates a safe environment for discussion. The group agrees to communicate respectfully and to use a round-robin format to ensure that everyone has the opportunity to speak. The facilitator explains her purpose at the meeting as being one to provide organization and keep the discussion moving in a positive direction, not one of offering her opinion. She begins with a story.

MENTORING

One-on-one consultation lacks the diverse perspectives available in consultation groups but allows for more spontaneous interactions, more personal attention, and a safe environment for those who find it difficult to speak openly in groups.

Mentors influence and shape us by sharing who they are, not just what they know. The study of ethics is about learning how to live and grow and contribute as a human being, as well as a professional. Select a mentor who is not afraid of sharing his or her mistakes, as well as personal and professional successes. A role model is not a perfect human being, but rather someone who is very much like yourself. Marsha Sinetar, in *The Mentor's Spirit*, says, "Show me your mentor and I'll show you yourself."[13]

Select a mentor who:

- Is available weekly by phone
- Is available monthly in person
- Has more professional experience than you
- Is committed to your growth
- Has qualities important to you, such as compassion, wisdom, and an ability to grapple with issues unflinchingly

Summary

Create an ethical business. Review and revise your business practices regularly.

- Charge reasonable and consistent fees for services.
- Set standards for identifying when treatment is complete and wellness care begins; then bill appropriately.
- Provide appropriate treatment and bill for the services provided.
- In your charts, do not misrepresent the patient's health or the treatment performed.
- Chart patient sessions in a timely fashion.
- Represent your services accurately. Discuss treatment outcomes honestly and realistically.
- Provide services within your scope of practice. Refer out for services that are outside your scope.

- Prepare patients adequately for draping and massage procedures and practices.
- Obtain written and informed consent to treat.
- Obtain additional written and informed consent to alter standard draping protocols and to treat sensitive areas, such as breasts and pelvic floor (NEVER touch genitalia).
- Discuss disagreements about the treatment plan or patient care directly with the referring HCP, never with the patient.
- Support the patient in addressing conflicts with other providers directly.
- Integrate privacy and security rules, regardless of HIPAA status.
- Request permission from the patient to discuss the case with other members of the health care team.
- Limit all conversations with the health care team to information pertinent to the patient's condition.
- Consider ethical and scope of practice/legal considerations before selling products or using fee-splitting–style advertising.
- Be an active student of ethics.
- Develop your ethical beliefs through discussion with peers and mentors.
- Consult your peers and mentors when problems arise in your professional relationships.
- Mentor others.

FROM THE LITERATURE

Discover What Lies Within

I leave you with the following as an inspiration to be in relationship: It is during interactions with others that we discover what lies within us. That is the gift of our profession—the gift we offer our patients through our listening and the gift we give ourselves through mentoring.

"We usually look outside ourselves for heroes and teachers. It has not occurred to most people that they may already be the role model they seek. The wholeness they are looking for may be trapped within themselves by beliefs, attitudes, and self-doubt. But our wholeness exists in us now. Trapped though it may be, it can be called upon for guidance, direction, and most fundamentally, comfort. It can be remembered. Eventually we may come to live by it."

Reprinted with permission from Remen RN. *Kitchen Table Wisdom: Stories That Heal*. Sydney, Australia: Pan Macmillan Australia; 2002.

References

1. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU15A.html.
2. Madison Mahoney V. Setting your fees: important factors to consider. *Washington Massage J*. 2003:10-11.
3. Peick JC. Are you committing billing fraud and didn't know it? *Washington Massage J*. 2005:35.
4. Burwell SM. *Cabinet Exit Memo, U.S. Department of Health and Human Services*; 2017
5. https://www.law360.com/articles/565596/health-care-kickbacks-cover-more-than-you-might-think.

6. https://www.patientpop.com/blog/marketing/groupons-really-attract-new-patients/.
7. https://www.advisory.com/daily-briefing/2011/09/29/are-groupon-discounts-for-medical-services-legal.
8. Miale Gix B. Legal memo: setting the record straight on HIPAA. What is and is not required in a medical authorization. *Advocate*. 2003:1-2.
9. Resnik DB. *What is Ethics in Research & Why is it Important?* National Institute of Environmental Health Sciences—National Institutes of Health. http://www.niehs.nih.gov/research/resources/bioethics/whatis.cfm. Accessed October 20, 2010.
10. SohnenMoe CM. *Business Mastery: A Guide for Creating a Fulfilling, Thriving Business and Keeping It Successful*. 5th ed. Tucson: SohnenMoe Associates, Inc.; 2016.
11. Wheatley MJ. *Leadership and the New Science: Learning About Organization From an Orderly Universe*. 3rd ed. San Francisco: Berrett Koehler Publishers, Inc.; 2006.
12. Taylor K. *The Ethics of Caring: Honoring the Web of Life in Our Professional Healing Relationships*. 2nd ed. Santa Cruz: Hanford Mead Publishers; 1995.
13. Sinetar M. *The Mentor's Spirit: Life Lessons on Leadership and the Art of Encouragement*. New York: St. Martin's Griffin; 1999.

CHAPTER 10

Researching and Writing Case Reports

After mastering the concepts in this chapter, the student will be able to:

- Acquire research literacy skills
- Apply three components of evidence-informed practice to clinical reasoning
- Formulate a hypothesis for a case report
- Identify a style of case report appropriate for the hypothesis
- Carry out a literature search
- Build an introduction based on the literature search and hypothesis
- Design a treatment plan, integrating current knowledge, patient preferences, and research
- Write a case report using the academic scientific format

Naomi, Lin Pak's massage therapist, did not have a great deal of experience working with Type 1 diabetes prior to Lin. In her several years with Lin, her experience and knowledge grew. She did periodic searches of the literature on the Internet and PubMed to learn about the condition. Initially, she wanted to ensure she understood the complications of diabetes and know of contraindications she needed to be aware of, so she started with a good pathology textbook (*A Massage Therapist's Guide to Pathology* by Ruth Werner). She was also concerned about concomitant conditions and wanted to learn the symptoms to watch out for. Then she searched online and found the Diabetes Association Web site (http://www.diabetes.org/) and read up on health problems associated with diabetes and self-care tips. Next, she looked for a government site to begin to explore the research and found statistics and source information on the National Institute of Health Web site (www.niddk.nih.gov/health-information/diabetes).

After gaining confidence, she was curious to see if there were other techniques she might apply and searched for strategies that had been found useful. She looked on PubMed (www.ncbi.nlm.nih.gov/pubmed/). Her initial search terms included massage and diabetes, and topical pain relievers and diabetes, knowing these where two areas in her scope of practice. Articles on peripheral neuropathy and peripheral artery disease, which are serious conditions associated with diabetes, showed that foot massages, with the addition of topical pain relievers, such as capsaicin and menthol, were helpful in preventing and relieving the complicating conditions.[1,2,3]

Because of her research, Naomi could incorporate new information and confirm some techniques she had already been incorporating. She made sure to always include leg and foot massages, using a topical pain cream or gel, in her sessions with Lin.

Introduction

Manual practitioners alike would agree that clinical practice strategies are heavily influenced by intuition. According to research, intuition is a finely honed skill, one that relies on collecting, retrieving, and reflecting on scores of information stored in the brain.[4] Scientists have applied the theory of intuition to the clinical reasoning practices of physicians, stating that gut feelings—alarm and reassurance—play a substantial role in the diagnostic reasoning processes.[5] Clinical reasoning relies both on the application of previous knowledge and the practitioner's ability to discern, reflect, and integrate new information as it appears.[6] It is reasonable to conclude that intuition—the ability to make a decision based on a feeling or "knowing"—is enhanced with increased data, experience, and openness to alternative approaches.

In a massage session, data are collected from the patient (history, symptoms, treatment preferences) combined with the results of a physical assessment (palpation, observations, movement tests) and compared with previous experiences with similar cases. This has been the standard for many years with noted success. Only in the past few decades has a cache of research become available, research specific to massage therapy, to add to the mix. Research does not replace clinical experience; rather, research applies clinical experiences to large populations of patients with similar conditions so that we may better understand how and when massage works to help inform effective and efficient decisions based on the individual needs of patients.

If we are to rely on research to enhance our conscious and unconscious clinical decision-making abilities, we need to ensure that the research is representative of our profession. Traditionally, researchers develop hypotheses based on a documented body of knowledge of a given practice and previous research. Case reports are the foundation for describing clinical practices for most health care disciplines; bodies of knowledge are built on this information. However, there is a limited cache of case reports on massage therapy practices. It is important for us to build up the database of clinical information and tell the stories of our patient interactions, describe who we are, what we do, and why we do it to ensure research reflects our practices.

It is encouraging to know that researchers respect intuition, honor our clinical experiences, and invite our input. It is exciting to learn that rigorous studies representing massage as practiced exist. It is our responsibility as manual therapy professionals to explore why massage is effective, investigate what works, and critically describe and analyze our practices. Use the data that exist to inform your treatment plans. Share current, available studies with referring health care providers (HCPs) and educate them on how to best use our services.

In essence, become consumers of research. Better yet, contribute to the research and write a case report. This chapter will provide a simple outline on how to find research, tools to critically evaluate it, and guidelines on how to incorporate it into practice. Next, once you gain experience in incorporating evidence into treatment and wellness sessions, learn to share your knowledge with each other, with other HCPs, and with researchers by writing case reports and getting them published. Case report guidelines and formats are provided, including tips on how to get them published.

Role of Research in Education, Clinical Practice, and Case Reports

Research is about asking questions and exploring answers. It is about searching systematically for solutions to problems, providing rules to guide your search. It is also about helping you to evaluate the research of others.[7] Science as a way of thinking is based on a spirit of open-minded curiosity and inquiry, using applied common sense and systematic procedures.[8] A preeminent researcher of massage therapy, Dr. Edward Ernst, said it best: "Unquestionably, the best reason for doing research is to become one step closer to the truth and to help patients."[9]

Research is a key to professionalization of any field. Not only knowledge, skills, and competencies or abilities (KSAs) must not be defined by a discipline to gain professional status, but also practitioners must continually update their KSAs to remain in good standing. In education, research can validate the KSAs, assisting educators in teaching current, relevant, and accurate information and prompting practitioners to provide safe and effective practices. Research helps establish the validity of our work by distinguishing useful practices from those that offer little or no benefit or may even prove harmful. It supports and informs our theoretical constructs and uncovers new options to consider.

In practice, research enhances communication with allied health professionals through a common language. Referrals depend on documented results through rigorous scientific studies; massage therapy cannot be included in insurance plans, massage therapists cannot be named on credentialed provider lists, nor can regulatory bodies make sound decisions without evidence of safety and effectiveness.

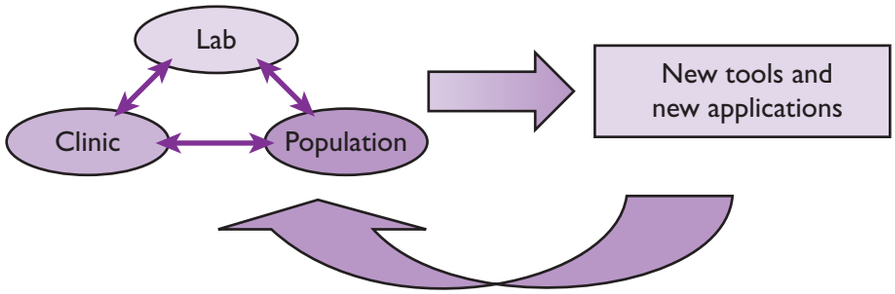
It is important to know if the claims we make are true and reliable, and that our treatment plans are effective, efficient, and safe for the young and the old, the healthy, and the infirmed. It is profitable to demonstrate that our care is cost-effective and that people prefer massage to conventional remedies such as prescription pain medication. Research can give our patients and their HCPs the confidence that massage is a viable treatment option for various health conditions. The data can be used for marketing to HCPs and to increase opportunities for health care reimbursement.

Research can teach us:

- what is safe and effective
- when it is safe and effective
- how it is effective

By definition, **integrative health care** makes use of all appropriate therapeutic approaches, health care professionals, and disciplines for which there is some high-quality scientific evidence of safety and effectiveness to achieve optimal health and healing.[10] In the 2010 strategic plan for the National Center for Complementary and Alternative Medicine (NCCAM) (now the National Center for Complementary and Integrative

FIGURE 10-1. Translational Research Diagram



Health [NCCIH]) put forth in its strategic plan that all complementary and integrative health practitioners should be research literate and be able to incorporate evidence into their practice decision-making, and that some complementary and integrative health practitioners should become research capable.[11] If we are to have a seat at the table of integrative health care and in health care reform, we best heed NCCIH's call.

TRANSLATIONAL RESEARCH AND EVIDENCE-INFORMED PRACTICE

Historically, **translational research** is a function of interpreting the data and incorporating it into our clinical practices. This is often coined bench-to-bedside—transferring information from the laboratory to the patient. Today, translational research is equal parts bench-to-bedside and bedside-to-bench. Practitioners are expected to relay clinical experiences back to the researchers and inform future studies. It is as important for us to influence the research as it is for research to influence us (Figure 10-1).

Evidence-informed practice promotes a three-pronged approach to treatment planning that takes into consideration all components of clinical reasoning. A health care practitioner formulates meaning, goals, and strategies by combining:

- current available research data
- practitioner experience and judgment
- patient preferences and presenting factors

Traditionally, clinical decision-making or treatment planning decisions are influenced by two of the three strategies. We ask questions of our patients, gathering history, symptoms, activities of daily living (ADLs), and desires. We perform a variety of assessments—posture, movement, palpation—and record our observations and measurements in session notes or on various measurement tools. We begin each session by designing an approach that will meet the needs of the patient based on our experience, training, and skills, given their presenting factors and preferences, and we modify it continually, as we evaluate the patient's response to our touch.

Research can contribute to this process by adding to our knowledge base. There are several areas where research can provide information that may influence our decision-making:

- patient population demographics
- common conditions, complications, and contraindications
- known results from clinical trials
- known physiological responses to types of touch

TALES FROM EXPERIENCE

Research Data Contributes to Whiplash Treatment

I began specializing in the treatment of patients with whiplash injuries 30 years ago, while sharing space with a chiropractor. My expertise developed as a result of my personal experiences and the succession of patients we began to share. My knowledge of whiplash at that time was limited but growing.

Dr. Lisanne encouraged me to take a seminar: Whiplash and the Chiropractic Personal Injury Case. The primary speaker was a chiropractor, Dr. Dan Murphy of California, an insatiable consumer of research. Unexpectedly, I was exposed to a world that stimulated my thirst for knowledge and provided provocative yet substantiated information that often challenged conventional treatment. I not only felt supported in the work that I was already doing, but I also learned to look for things I didn't realize were related to motor vehicle injuries. I learned that you can get a concussion without hitting your head on anything, that knee injuries are common in car accidents because of the ramping effects caused by cushiony seats, and that the loss of postural control could be attributed to swelling at the base of the brain, a result of the hyperextension/hyperflexion of the cervical spine.

My treatment plans began to shift to reflect my newfound information. I asked new patients about their knees, posture, and memory in the initial interview so that I could document the symptoms as a part of the case instead of wondering if I should ignore these seemingly unrelated conditions and stick to treating the neck. I began focusing lymph drainage at the base of the skull to affect the swelling and using movement reeducation to enhance postural perceptions and improve small muscle control. I documented knee injuries, memory lapses, and jaw pain.

I might have learned much of this on my own over the years, but I quickly became adept at treating whiplash because of the research.

Statistics can prove helpful when learning about a particular demographic or condition. In the older adult population, for example, the statistics are compelling. The demographics of aging are dramatically changing with the baby boomers coming of age. An increasing number of people are living longer and working longer.[12] The elderly population will increase from 46 million in 2016 to over 98 million by 2060, rising from 15% of the total population of the United States to over 24%. They will be more racially diverse and better educated with a higher median income compared with previous generations.[13] CIHC use is more predominant among people with higher incomes and more years of education.[14] Therefore, the likelihood of massage therapists seeing an older adult in our practices is increasing, because of not only the increase in population of older adults but also the increase in income and education of this group. Given the information on older adults, one might be drawn to learn about the aging process, common conditions, and appropriate treatment techniques.

Common conditions and associated complications, and contraindications can be gathered either from a general search or by searching research databases. A combination of both will provide the most comprehensive information. General searches can tell you the number of older adults who experience falls each year, the prevalence of arthritis, or the mortality rates resulting from cancer in people older than 65 years. Exploring the abstracts and introductions of many studies can provide valuable details on the standards of care for treating the conditions, and the complications and contraindications found therein.

Rely on the research databases for exploring massage as a treatment for balance, arthritis, or other symptoms of aging. Investigate the mechanistic data on how massage is effective for treating those conditions or symptoms and the clinical trials for which types of massage have been found to be safe and effective for each.

RESEARCH STRUCTURES, METHODS, AND LEVELS OF EVIDENCE

Clinical trials provide data on how patients respond to various treatment techniques—in essence, what works and when. They tell us nothing about *how* or *why* those techniques work. To understand what is going on underneath the skin—what makes massage effective—researchers go to the laboratory. This is called bench science or mechanistic research. In the laboratory, blood is drawn and analyzed; electrodes are hooked up and brain patterns are studied; rat tissue is dissected and studied after treatment is administered. Cortisol has been touted as the chemical that explains why massage works, but without complete satisfaction. H-reflexes and brain imaging are under review currently and may better explain the body's response to intentional touch. Even now that the evidence base has grown, we know very little about the how and why massage works. Still, it helps to review the mechanistic studies and learn how massage affects heart rate, blood pressure, blood chemistry, and the nervous system.

Mechanistic studies and clinical trials or human subject research are two different types of research. Within the various types of research there are different styles or formats for conducting research, such as case reports and randomized controlled trials (RCTs), and different methods or approaches to gathering information, such as qualitative and quantitative data. It is helpful to have a general understanding of each of these before launching a literature search, critically analyzing the data, and attempting to apply the information to clinical practices.

The Research Pyramid

Examine different research and critique the power to ascertain if the outcome was a direct result of the treatment. This is known as **levels of evidence** (see Figure 10-2). The research pyramid or evidence hierarchy rates the power of various types of evidence and defines the pathway an idea or hypothesis takes as it is tested, undergoing increasingly more rigorous examination before it can be accepted as evidence.

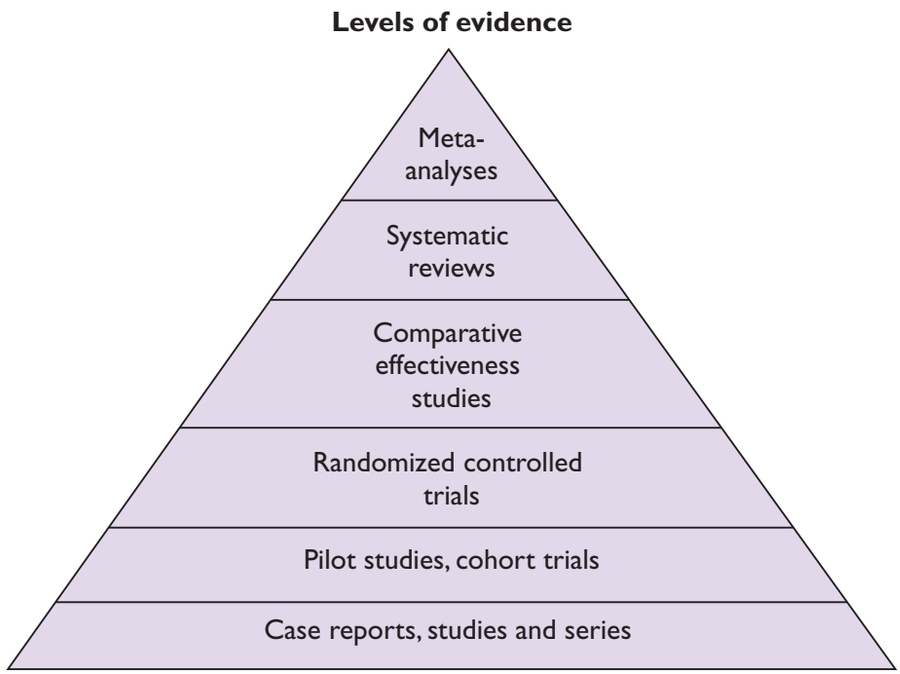
Levels of evidence are like giving the research design a grade. An "A," or the highest level of evidence, is awarded to studies that provide information that is applicable to a large group of people. This is known as **generalizability**.

Bias also plays a role in determining the level of evidence. Reducing bias, or the study's ability to ensure that the results are directly related to the intervention and not to chance or other outside influences, is the goal of every researcher reaching for high marks.

Case Reports, Studies, and Series

Case reports are the critical beginning to any research study and form the base of the research pyramid. A case report documents and describes an interaction between one practitioner and one client. For example, a massage therapist has an older patient debilitated by a lack of sleep. After several massage sessions, the patient's sleep improves, thereby improving his or her ability to function physically and socially. The practitioner writes up the interaction, reporting the prevalence of insomnia in the older adult population and the current standard of care, and describes the effects of sleeplessness on this patient. The treatment and outcomes of this relationship are also described in detail. The results only

FIGURE 10-2. Levels of Evidence



show how one person reacted to the intervention of one practitioner and are therefore not generalizable to a larger population. However, case reports are useful because they offer a perspective on what is possible and suggest what might warrant further study.

Case reports detail symptoms, diagnosis, treatment, and quantitative outcome measures, whereas case studies are qualitative and involve observing subjects in real-life settings. This method of research is more commonly used in sociology and psychology than manual therapy. Often these terms are used interchangeably, though case reports, as defined, represent the study design most used to document manual therapy interactions.

A case series, or clinical series, typically involves more than four but no more than ten patients with a similar condition and intervention and examines their medical records for outcomes. These do not involve hypothesis testing, unlike studies higher up the pyramid that employ analytical design. Case series are especially vulnerable for selection bias and may not represent a wider population.

Bias is inherent in all $N = 1$ studies. The patient has already chosen the practitioner and the type of treatment, so he or she is invested in the success of the treatment more so that being randomized into an unknown protocol with an unknown practitioner, as in a tightly controlled clinical trial.

Case reports are a low level of evidence. The data are not generalizable and bias is inherent.

Pilot Studies

Once an interest is identified (sleep disturbances in older adults) and a **hypothesis** is formed (can massage improve sleep in older adults?), a pilot study can be used to test the theory on a larger group of people. This type of study helps identify the feasibility of, and refinements for, further study. A pilot study does not include a comparison or control group and often uses a small set of participants, more than 1 but usually less than 50. A pilot study is an opportunity to see if the study design was effective in answering the question

posed in the hypothesis. Once the protocol (intervention or treatment techniques) and methods (the selection of participants, the application of the protocol, the measurement tools, etc.) are tested and refined, a comparison trial or RCT may be conducted.

Bias is slightly less in pilot studies than in case reports. The participants are recruited from outside: they are not from inside the practitioner's existing clientele, nor do they select the practitioner, But with only one intervention provided in the study, they are agreeing to receive a known treatment, tending toward bias.

Pilot studies are more generalizable and have less bias than case reports, and therefore have more power or a higher level of evidence.

Randomized Controlled Trials

RCTs compare two or more clinical interventions to help determine which treatment is best for an identified population. RCTs involve recruiting a large number of participants (often hundreds) with a particular condition (sleep disturbances), ruling out many complicating conditions so that the population is as pure or controlled as possible (Alzheimer, recent surgeries). A computer program or other blinded selection process randomly funnels them into one of a few different arms of a research project (music therapy, aromatherapy, massage therapy). In randomized trials, the participants do not select the type of treatment nor do they select the practitioner, thereby limiting bias.

The term controlled often refers to a placebo treatment: something that looks like the intended intervention but doesn't contain any healing properties. Placebos are difficult to design for manual therapies. One problem is that we have yet to identify which component of massage therapy—one-on-one interaction, healing intent, touch itself, relaxing environment—is most critical in an intervention, or if the combination of the various aspects of a session makes the intervention effective. If an individual component of massage can be isolated, the problem becomes how to remove the healing properties of it to create the placebo—virtually impossible.

Control groups may then become comparison groups, as in the example above, comparing massage therapy to music therapy or aromatherapy. Often, the comparison groups include a "usual care" arm—a continuation of what the HCP has prescribed, such as stretching or exercise—to demonstrate if massage therapy is more or less effective than the standard of care.

RCTs are generalizable and limit bias, obtaining the gold standard seal of approval for clinical trials. That said, RCTs often do not capture the essence of a typical manual therapy session. For example, one session could incorporate all of the comparison group's protocols: music, scents, stretching, and self-care.

Comparative Effectiveness Research

More recently, to promote advances in research and research methodology, a new research institute was created and authorized by Congress. The Patient-Centered Outcomes Research Institute is an independent, nonprofit and nongovernmental organization. A trust fund was established by Congress through the Patient Protection and Affordable Care Act and funded through additional sources to support its mission to improve the quality and relevance of evidence available to help patients, caregivers, clinicians, employers, insurers, and policy-makers to make better informed decisions by funding a new kind of research. To do this, the institute works with stakeholders to identify critical research questions and answer them through **comparative effectiveness research**, focusing on outcomes important to patients and disseminate the results in useful ways. Since 2012, they have funded hundreds of studies that compare health care options to learn what works best, given patients' circumstances and preferences.[15]

CER research is expensive, even more so than RCTs. It is designed to compare different health care interventions to determine which are best for various conditions and populations. Most previous research selects one intervention and compares that to a control group. In manual therapy, this can mean comparing the whole practice of massage therapy, mindfulness, and yoga for low back pain, for example, in one study, rather than parsing out one technique and comparing that to a control group. Seven steps are involved in conducting this type of research:

1. Identify new and emerging clinical interventions.
2. Review and synthesize current medical research.
3. Identify gaps between existing medical research and the needs of clinical practice.
4. Promote and generate new scientific evidence and analytic tools.
5. Train and develop clinical researchers.
6. Translate and disseminate research findings to diverse stakeholders.
7. Reach out to stakeholders via a citizens forum.[16]

Systematic Reviews and Meta-analyses

Systematic reviews and meta-analyses are a form of secondary research, also known as desk research, and involves the summary, collation, and analysis of existing research. Meta-analyses go a step beyond systematic reviews and combine and synthesize data from like studies to create a larger pool of evidence. For example, a search is done on "massage and sleep" and 300 articles are identified. The articles are eliminated or included according to set criteria, resulting in 50 articles. Measurement tools are evaluated and commonalities are identified to combine the data. Inclusion/exclusion criteria often eliminate studies that are not generalizable or where bias is evident, producing data that represent the highest level of evidence available.

Many meta-analyses only consider RCTs, putting massage research at a disadvantage because of the comparatively few number of RCTs involving massage interventions. As a result, many meta-analyses in the past simply say there are not enough data to draw conclusions on the effectiveness of massage therapy. However, three systematic reviews with meta-analyses embedded in the article were published recently on massage therapy and pain, based solely on RCTs, that are having a profound impact on the landscape of research and the use of massage therapy. These articles look at the impact of massage on pain and function for general populations, cancer, and surgical patients. Every massage and bodywork practitioner (or any manual therapist whose work has roots in massage therapy) should download these articles, read them, and have them available to share with any patient and referring HCP.[17,18,19] These articles provide a solid base of support for massage therapy as a health care intervention. We can point to these seminal works anytime someone refutes the legitimacy of massage and bodywork practices for the treatment of pain conditions.

Methods for Data Collection

In social sciences or human subject research, the following three methods for collecting information can be applied, depending on the properties of the subject matter and on the objective of the research:

- Qualitative research: descriptive data collected in the form of words rather than numbers, with the intention of better understanding of human behavior and the reasons that govern such behavior, often collected through observation or by asking open-ended questions of the subjects in a natural setting

- Quantitative research: numerical data acquired through systematic empirical investigation of measurable properties and phenomena and their relationships, with an emphasis on controlling the environment and reducing the probability that the results could have occurred by chance
- Mixed-methods research: a combination of qualitative and quantitative research, often gathering measurable data and survey data to help illuminate patterns that might have otherwise been overlooked[8]

Case reports are often considered both quantitative and qualitative research because of the combination of measureable outcomes and the descriptive nature of the therapeutic encounter, whereas RCTs are primarily quantitative. Both contribute to the body of knowledge and the evidence base for massage therapy and will be considered throughout the chapter.

Case Reports: Purpose and Structure

Case reports are an ideal format for telling researchers, referring HCPs, and policy-makers who we are (complex, patient-centered, and whole-body focused), what we do (more than just a back rub), why people choose us (we touch more than their physical pain), and how powerful intentional touch can be. Massage therapists by law are not able to diagnose, leaving us free to see patients as human beings to partner with, rather than only relating to the illness—something to name and eliminate. Our stories will likely not focus on unusual conditions or describe novel treatment procedures because our ordinary client approach is still unusual to many. Our job is to illuminate the reader of the totality of a manual therapy session.

TALES FROM EXPERIENCE

Case Report Winner

"I loved doing the research, reading other people's [case] studies, poring through [research] articles, the whole process! The challenge of the work in practical application and the rewards of having a happy research client made my school experience so much more. I have been reading about massage research since graduation, as it deepens my practice and provides a firm foundation for the work that I do," Jenny Dailey, a student of the Brian Utting School of Massage (now Cortiva-Seattle), commented in an interview after winning the 2008 silver award in the Massage Therapy Foundation (MTF) case report contest.[20] Her article, "Bulimia nervosa and massage: a case report examining body awareness with co-morbidities anxiety and depression," described a series of student-massage sessions Dailey provided a young woman with bulimia and told of the benefits massage provided: enhancing body image and awareness, and reducing anxiety and depression. These stories are interesting and uplifting to the student and practicing manual therapist; case reports are educational to practitioners, referring health care providers, researchers, and the public, informing stakeholders of the impact that intentional touch can have on health and wellness.

OBJECTIVES OF WRITING CASE REPORTS

Case reports consist of a detailed description of an individual client interaction, coupled with a literature review of research on similar subject matter. They tell of our day-to-day experiences and pose the questions we contemplate in our practices. Case reports may focus on the norm, describing a typical client, assessment tools, or technique application, or it may tell of an unusual outcome or unique approach to a condition or disease. A case report that is well-observed and linked to published literature can be valuable even if there is nothing unique in the details.[21]

Case reports stimulate learning and research; they complement other evidence-informed health care.[21] Practitioners can learn from each other's successes and failures without being in close proximity; internships are sorely lacking in our profession, making sharing knowledge through case reports even more critical. Results of a single case report cannot establish cause and effect, but they can lead researchers to do the kinds of studies that might. Most importantly, they develop critical thinking and problem-solving skills that hone our aptitude as practitioners.

Case reports are considered anecdotal evidence, and as such, are less scientifically rigorous than controlled clinical or comparative trials involving a larger sample size. Proponents argue that case reports have scientific value because of the role in discovering new diseases and unexpected effects (adverse or beneficial) and educational value because of the descriptive nature. They are considered one of the cornerstones of medical progress and are encouraged in biomedical medicine.[22]

Interactive blogging sites exist, inviting HCPs to submit their medical case reports and help solve other cases.[23] There are an increasing number of peer-reviewed journals that are encouraging the submission of case reports (*BMJ*, Elsevier) or have launched journals dedicated to compiling case reports (*The Journal of Medical Case Reports, The Case Report Journal, The International Case Reports Journal*). The call for contributions to the evidence base from individuals in the field is on the rise, across conventional and alternative disciplines.

STYLES OF CASE REPORTS: EDUCATIONAL, ASSESSMENT, AND TREATMENT/MANAGEMENT

There are three presentation styles for writing case reports: educational, assessment, and treatment or management.

Educational case reports illustrate common situations and are used to establish a baseline for practices. Individual aspects of a practice are described—intake procedures, assessment tools, treatment techniques, and homework assignments—for typical conditions so that atypical presentations have a comparison. This style is used to depict who we are, who our clients are, what we do, and how we do it. Outcomes are not the central focus of educational case reports. Basic information recounted with great detail is paramount; these reports build the foundation that defines our work.

Assessment case reports describe and discuss analytical methods used to evaluate a client with uncommon conditions. This assumes documentation exists for common conditions. In the case of many manual therapy disciplines, standard assessment protocols are not entirely defined. This opens the door for us to define the assessment tools and techniques used for particular conditions, common or uncommon, so we can begin to culminate standard practices. This style of case report invites us to go beyond identifying the tools and techniques we employ and pushes us to describe our clinical decision-making process: why did we pick that tool and how did it influence our treatment plan. A

good example of this type of case report is "Clinical Reasoning in Massage Therapy" by Kim LeMoon,[6] which spoke of a series of interview questions that helped her identify the source of her client's pain, changed her treatment approach, and finally provided the client relief.

Treatment or management style case reports are most common. A treatment-focused report follows a client through a session or series of sessions and describes everything from the client profile to the treatment outcomes. The client's condition is discussed, including a full literature search on the condition, symptoms, and common treatments. The treatment plan is identified, and its implementation described in detail. Subjective and objective measurements from before and after the treatments are compared and outcomes are charted on graphs. Outcomes are the primary focus, detailing each step along the way. The majority of case reports submitted to the MTF's case report contest follow the treatment style of reporting. Go to: http://massagetherapyfoundation.org/grants-and-contests/case-report-contest to read the case reports available.

TYPES OF CASE REPORTS: RETROSPECTIVE, PROSPECTIVE

All three styles of case reports can be written from either a prospective or retrospective approach. Prospective reports are conducted in real time. A client is identified, one that presents a particular challenge or represents a common profile. A literature search on the presenting condition is conducted in advance of the treatment and influences the clinical decision-making (evidence-informed practice!) Assessment protocols are predetermined; results are carefully measured and tracked over time. The treatment plan is also predetermined but can be modified if documented based on the client's progress and preferences.

Retrospective reports are identified and compiled after the sessions have been completed. Perhaps after reading this chapter you are prompted to tell a client story from last year, one that taught you much about relieving the chronic pain. It is acceptable to go back into your files to write up the sessions with Sophia, the feisty 76-year-old with osteoarthritis. Consistent use of measurement tools and clear chart notes or progress reports that describe clinical reasoning, outcome measures, and the methods of care provided must be documented to write up a retrospective study.

Key Components of a Case Report

There are several steps in preparing for a case report.

1. Identify a condition or situation, one deserving of your time and effort, which you wish to explore further or describe in detail. You should feel compelled to investigate it, analyze it, or learn more about it (assessment or treatment reports); or have a strong desire to share what you know, document it, and make it available for others to learn from (educational reports).
2. Develop a hypothesis. Pose your thoughts in the form of a question, reminding yourself that this is an exploration, not a known fact (assessment or treatment reports). In an educational report, define the parameters of that which you wish to describe.
3. Conduct an extensive search of the research literature, revealing what is known about the condition and what treatments are considered standard. In an educational report, identify what else has been published on the chosen aspect of a clinical encounter, describing common practices for similar disciplines. Stick to original research rather than textbooks whenever possible.

4. Apply clinical reasoning skills to the development of a treatment plan. Consider the literature, common practices, and patient preferences, and identify assessment techniques, measurement tools, and treatments and modalities (assessment and treatment reports).
5. Consider the ethical implications of the intervention, the compilation, and dissemination of information on the patient's well-being and privacy. Apply strict rules of confidentiality throughout the project.

HYPOTHESIS DEVELOPMENT

As previously stated, one must identify the subject of the case report before moving forward. Do you have a client with a particular condition that you would like to learn more about or are effective in relieving? Or are you more interested in knowing if others do what you do? Is there one aspect of a client interaction that interests you, or do you wish to tell the whole story? Narrow down your interests and outline the story you wish to tell.

The story outline identifies the demographics of the patient, the condition, the intervention, and the proposed outcome. Posed as a question, it becomes your hypothesis. A hypothesis is a tentative assumption made to draw out and test its logical or empirical consequences (assessment or treatment reports), or an interpretation or explanation of a practical situation or observed phenomenon (educational reports).

In keeping with the examples, there are several possible hypotheses one might be interested in testing. The older adult population can benefit from massage therapy in many ways that have some evidence behind it, by addressing conditions such as osteoarthritis, or symptoms such as loss of balance, sleep disturbances, pain, and constipation. Or you may have found benefits that are not yet in the literature, such as the use of massage to delay joint replacement in older adults, or to renew activities previously abandoned. Any of these could make a compelling case report.

Here are some examples of hypotheses:

- Can older adults with osteoarthritis of the knee find relief from chronic pain with a full body Swedish massage?
- Does foot massage combined with resistive stretching and topical analgesics improve balance in older adults who have suffered from recent falls?
- Can manual lymphatic drainage and movement reeducation delay hip replacement surgery in an active older adult female?

TALES FROM EXPERIENCE

Cases from My Private Practice

Although I have been in practice for 35 years, I was surprised to discover that my patients are also getting older. Many are now 70 and 80 years old and going strong. Others have survived cancer, undergone multiple surgeries, have pacemakers, or simply want to be more active. I found I needed to enhance my skills in working with the older adult population. Although the demographics can be alarming, many of my long-time patients were beating the odds. Here are two great stories to share.

(Continued)

TALES FROM EXPERIENCE (*Continued*)

Cases from My Private Practice

Sophia, an active 76-year-old, was scheduled for hip replacement surgery. She wasn't ready. Her daughter was undergoing surgery the following month and needed her mother's care, she was planning a trip to Europe with friends, and golf season had just begun. She came to her massage session with a goal of delaying surgery for 6 months. She knew the need for surgery wasn't going to go away, but she wanted to be active for a while longer without the pain getting the best of her. We increased the frequency of massage visits, changed our plan to assess functional improvement, and ended up delaying her surgery for 18 months! She was able to golf for two more seasons, walking nine holes one to two times per week.

Grace was another shining example of what is possible at age 75 years. She had been a competitive horse driver, an equestrian sport involving carriage driving, winning many national competitions in her day. Her horse driving days were over, but she longed to ride horseback for the sheer joy of it. Fear had stopped her from riding nearly a decade ago, because of her progressive loss of balance and strength.

Recognizing her limitations, she took up weightlifting and Pilates, and we shifted the goals of her massage sessions to focus on increasing balance and flexibility. When she was ready, the horse trainer set up a stepping station to assist her onto her favorite horse. Despite the horse's height—over 15 hands—and young age, she rode fearlessly that summer. When she retired the second time, it was by choice and with great pride.

LITERATURE SEARCH

Information from research can help determine if a population warrants further inquiry and provide statistics and tested theories to inform clinical decision-making. It is the foundation for a case report, grounding the subject in what is currently known.

Begin with a search for demographic information. A general use of the Web is easiest when searching for this type of statistical data. Use whatever search engine you are comfortable with—Google, Bing, etc.,—and type in "statistics on aging" or "statistics on older adults." Different search terms yield different results. Track your search terms so that you can repeat your searches, should you need to retrace your steps or avoid repeating failed attempts.

Select Web sites that are more likely to have large budgets for funding research. Government sites, such as www.hlm.nih.gov, www.aoa.gov, and www.aarp.org, draw from census data and other large surveys to compile statistics. Data from these sources are considered to be generalizable because of the large sample size, with high validity because they are reproduced every 2–5 years. However, they are primarily representative of US citizens and include little to no international data.

Although these sites can tell you the number of older adults who experience falls each year, none will tell you if massage is an effective treatment for balance issues or other symptoms of aging. Neither will they provide mechanistic data on how massage is effective for treating those conditions or symptoms or clinical trials that demonstrate which types of massage have been found to be safe and effective for each. Time to go to the medical research.

REFINE YOUR SKILLS

Search for Statistics on a Population of Interest

In class or at your networking group meeting, divide into small groups of two to four. Pick a condition, one your patients commonly present with or one you or a loved one live with. Choose a condition that is prevalent, not something obscure, such as cancer, arthritis, or fibromyalgia. As a team, ideally each with their own Wi-Fi connected mobile device, try different search terms, explore various Web sites, and compile demographic data. Report back to the class, sharing each other's search results, and learn about several populations of interest.

When searching for evidence in clinical trials or mechanistic data, use medical databases, like PubMed or BioMed Central—both are free, or search a directory of open access journals, https://doaj.org, when looking for a specific journal rather than a specific article. Although a general search of the Web is perfectly fine for statistics, many Web sites are not reliable for finding research data. Often, the research found on Web sites represents someone's explanations of the studies. It is important to use first-hand sources of information, or primary research, rather than someone's interpretations of the research. Type in "massage and older adults" or "CAM and older adults" into a research database and read many **abstracts**—research summaries—noting the common conditions and complications associated with this population. It is helpful to obtain a broad glimpse of the health conditions common to this growing population before attempting to construct a profile.

Based on general and research-specific search results, older adults were found to present with a wide range of conditions, making it challenging to identify a typical profile. Application of massage therapy for the older adult will vary depending on the presenting symptoms and conditions of the person receiving care. Massage practitioners are best served if they are knowledgeable about the range of health conditions common to this growing population. For example, 80% of older adults have at least one chronic condition and 50% have at least two chronic conditions. The most frequently occurring conditions among older adults were hypertension, hyperlipidemia, arthritis, heart disease, and diabetes.[24] Although the health status varies widely, three distinct categories came to light: healthy active older adults; older adults living with chronic conditions; and older adults requiring end-of-life care.

Go beyond the abstracts and read several articles to uncover specific conditions, the treatments explored, and the progress or complications that resulted. The in-depth information will help you develop an understanding for the needs of the population, and provide key information on how to improve your ability to provide safe and skillful care. If the full-text article is not available for free, copy the citation and plug it into a general search engine, such as Google™ scholar (scholar.google.com/). It might be available elsewhere on the Web. Another way to limit paying per article fees or subscription fees for each article is to do your searches in a University library. Universities subscribe to many scientific journals; students have access to them as part of their tuition. Many government-funded schools allow the public access to the libraries.

Continuing with the example above, healthy active adults were found to likely require attention to functional considerations, such as balance, pain with movement, and loss of mobility. Several studies used massage therapy, hydrotherapy, and movement techniques to increase range of motion, reduce pain, and in turn, improve balance.[25] In addition, people's mood changes when the pain is reduced, encouraging a more social and active lifestyle and reducing the need to be isolated and immobile, which compounds the effects of aging.[26]

PROTOCOL DEVELOPMENT

Let's apply the evidence to our clinical reasoning process. One way to build a treatment plan is to identify physiological and psychological goals, then select treatment techniques that will accomplish those goals. For example, the symptoms are chronic pain, decreased mobility, loss of balance, depression since giving up golfing, and anxiety when walking down stairs. The findings confirm a decrease in range of motion of the hips, knees, and ankles, trigger point pain, and fascial restrictions. The goals of treatment then become clear:

- reduce pain
- increase range of motion
- provide a calming sense of relaxation

Once the goals are identified, techniques can be selected that will help accomplish those goals:

- trigger point therapy to reduce pain
- stretching, resistive movements, myofascial release to increase range of motion
- Swedish massage to the whole body to calm and relax

As the treatments progress, the plan will change to accommodate shifting needs and patient preferences. The research provides options, giving us ideas about what has worked in controlled environments to accomplish specific goals, and reminds us to measure our successes, so we can try other approaches to treatment as we discover what isn't working.

REFINE YOUR SKILLS

Search for Effects of Massage Therapy on a Population of Interest

In class or at your networking group meeting, divide into the same small groups of two to four as in the previous Refine Your Skills. Using the same demographic search topic as before, search research databases for information on the topic. Combine the term with massage therapy, or CAM, and read many abstracts. As a team, ideally each with their own laptop, try different search terms and compile research data. Once you find several abstracts of interest, locate as many of the full-text articles as possible.

Report back to the class, sharing each other's search results, and present the articles you wish to read further. As a large group, choose one topic—preferably the one with the most available information—and complete the rest of the Refine Your Skills together.

Distribute the articles on the one topic among the group, giving each person one article to read. After the articles on one topic have been read—one per person—report back, share your findings, and determine what data can be culled from the body of evidence and incorporated into practice. Together, develop an evidence-informed treatment plan.

INSTITUTIONAL REVIEWS (IRBs)

An institutional review board (IRB), also known as an independent ethics committee, or ethical review board, is a committee that has been formally designated to approve, monitor, and review biomedical and behavioral research involving humans with the aim to protect the rights and welfare of the human subjects.[27] In the last years, experimentation was at times conducted on people without their consent, even without their knowledge, and occasionally at great cost to health, welfare, and human dignity. Thankfully, strict regulations and oversight were implemented to prevent this from recurring.

The question of whether case reports require this much oversight has been debated over the years, both by ethics committees and by journal editors who also comply with strict ethical regulations. Considering that case reports describe an occurrence that would have taken place in the normal course of a clinical practice, practices already protected by HIPAA privacy regulations and ethical oaths, they are commonly not subject to IRB review.

As is appropriate with any ethical dilemma, the question should be revisited periodically. A recent study surveyed 124 US medical schools if a single case report required IRB approval prior to presentation or publication. Seventy-eight percent reported did not require IRB approval for a case report. Of the remaining schools, none required a full IRB review.[28] In addition to this study, the consensus under the Common Rule for human subject research is that case reports do not constitute research as the government defines it.[29]

Follow the HIPAA guidelines summarized in Chapter 5, Documentation: Intake Forms, obtain written permission from the patient to publish his or her protected health information, and ensure the paper completely blinds his or her identity.

Case Report Structure

Case reports are written in accordance with a specified format to ensure the necessary information is included and easily found. The same or similar structure is used in writing up other types of research. Once you become a seasoned consumer of research, it will feel familiar and applying the structure to a case report will make sense. Adhering to the format will also make the review process smoother when submitting your paper for publication.

When you are ready to begin writing, follow this outline:

- Title, Acknowledgements
- Abstract
- Introduction
- Methods
- Results
- Discussion/Conclusion
- References

TITLE/ACKNOWLEDGEMENTS

The title of a case report succinctly describes the study, including who, how, why, and what happened. In the title, "Manual lymphatic drainage and movement reeducation therapy is used to delay hip replacement surgery in an active older adult female with osteoarthritis of the hip: A case report," the client (who) is described as an active older adult female. The intervention (how) is a combination of manual lymphatic drainage and movement

reeducation therapy. The condition (why) is osteoarthritis of the hip. The outcome (what happened) is delaying hip replacement surgery.

Write the title early on. It is a great way to identify the parameters of the study and clarify your intent. If the title doesn't get you excited, pick another topic. You may have noticed that the title is the hypothesis, stated instead of asked, with the outcomes already identified.

REFINE YOUR SKILLS

Create a Title for a Case Report: A Writing Exercise

Paper and pen in hand, reflect on the previous Refine Your Skills. Consider what topics you found interesting, if information from the group's search results discussions triggered a new thought, and if the hypothesis you developed continues to hold interest. Write down answers to the following questions: What is it that you are interested in investigating? Who have you worked with that would make an interesting case report? How have you approached the symptoms and conditions in the past? Will you try a new approach? From there, write a preliminary title for a case report, describing the patient, the condition, the intervention, and the proposed outcome. Remember, once the study is complete, the title may need to change, but for now, clarifying your intent up front can be a guiding light, illuminating your way through this new adventure.

On the title page of a case report, acknowledgments are made. It is an acceptable practice to involve others in conducting research, case reports included. You may enlist the help of a colleague, teacher, or mentor to assist you with your literature search, help you design the treatment plan, or edit your paper. Space is provided to thank those who contributed to the development of the project or the paper's revisions.

ABSTRACT

The abstract summarizes the study and must be organized using a standard format. Abstracts commonly include purpose of the study, methods, results, conclusions, and key words. The abstract follows the standard structure for the case report itself and simply retells the highlights of the study in an abbreviated format, limited to 150–250 words.

Key words are the only part of an abstract not found in the paper itself and are used to help with database searches. List words or phrases that will help people find your case report. Make sure the words or phrases are used in the title or abstract; this will ensure the words turn up at the top of a search result listing. In the example above, "massage therapy," "lymphatic drainage," "movement reeducation," "osteoarthritis," "chronic pain," "older adults," and "hip replacement surgery" may be helpful search terms. Listing the key words at the end of your abstract provides helpful search terms and assists in assigning papers to review committees or editors.

The abstract is brief (about 200 words) but conveys almost as much information as the paper itself. Make sure it passes the "so what?" test: Is the problem interesting? How did you solve it? What are the implications of the results? Omit any vague statements or assumptions. Write the abstract so that it makes sense all by itself.

The following is a sample abstract for the stated title, "Manual lymphatic drainage and movement reeducation therapy is used to delay hip replacement surgery in an active older adult female with osteoarthritis of the hip: A case report."

Introduction/Purpose

Osteoarthritis is the most frequently reported chronic ailment in the older adult population, affecting as many as 21 million Americans, and leads to chronic pain and limited function. Massage therapy has been shown to diminish symptoms and improve the course of osteoarthritis.[25] A 76-year-old female with osteoarthritis of the hip seeks massage therapy to reduce her pain and improve her function long enough to delay hip replacement surgery until the fall.

Methods

A licensed massage therapist applied two specific additional types of massage therapy: manual lymphatic drainage and movement reeducation therapy, during regular massage treatments. Sessions were 1 hour in length and occurred one time per week for 3 months. Pain and function were assessed using a 0–10 verbal scale; measures were taken before each session. ADL's were verbally solicited and recorded, noting activity, frequency and comfort.

Results

The patient was able to maintain a low level of pain, never exceeding 4/10 on the golf course, and was able to continue playing golf weekly or biweekly, walking nine holes. She missed two golf dates in 3 months because of pain.

Conclusions

The patient was able to delay her hip replacement surgery, commenting that she was able to maintain her normal activities and the pain was controlled with massage.

INTRODUCTION

The introduction describes the purpose of the study, providing background information on the condition or technique, and cites studies that support the hypothesis—why massage is reasonable and potentially beneficial for a client with this condition. In the example above, the introduction would include the following:

- In-depth information on the signs and symptoms of osteoarthritis
- Statistics on the prevalence of this condition in the older adult population
- Current research findings on the use of massage or similar modalities for osteoarthritis symptoms and conditions
- Research on treatments that delay joint replacement surgeries (it is common knowledge that joint replacement surgeries should be used as a last resort, so find out what remedies or strategies are currently recommended by orthopedic physicians)

The introduction provides background information, sharing details necessary for the reader to become educated on the various components of the report. Given the example, say why the reader should be interested in the older adult population, and how often

himself or herself might encounter osteoarthritis. The reader should learn as much about the condition—osteoarthritis—and the standard of care for the condition, to critically evaluate the approach of the author/practitioner.

The literature search is foundational for the case report and for any research paper. It is important for the author to demonstrate that he or she is standing on the backs of previous research; they have taken into consideration the work of others, learning from previous mistakes and omissions, and reinforcing treatments that have already been demonstrated effective. It is acceptable to experiment outside the norm: it is not OK to conduct research in a vacuum and ignore what has previously been discovered, even if the author chooses to use "experimental" treatment methods.

It is important to cite the best available evidence. Sources of information are considered primary, secondary, and tertiary, depending on originality and proximity. In scientific literature, a primary source of information is the original publication of a scientist's new data, results, and theories. An author citing this level of information is required to interact with the research and extract information directly. A secondary source represents an accounting of the primary data. The original information has been interpreted or evaluated by a second party. A tertiary source is based on secondary information, providing an overview of topics. Textbooks can be either secondary or tertiary and should not dominate a literature search. Cite primary research in your introduction whenever possible.

When gathering primary references, select research that represents a higher level of evidence than other studies on similar topics with comparative results. Another option is to provide multiple sources for one statement. Citing more than one source for a single piece of information will allow you to cite a wider range of evidence and include lower-level studies without diminishing the overall quality of the references.

METHODS/CASE DESCRIPTION

The Methods section covers two broad topic areas: the profile of the client and the treatment plan. The profile of the client includes a detailed account of how the condition affects the client—symptoms and changes in activities of daily living—and a medical history as it pertains to the condition. Also included are findings from other members of the client's health care team, including the physician's diagnosis and recommendations for care. Most importantly, address the client's desired outcomes, not just your own.

Exclude the patient's name and references to where he or she lives and works, or any information that might make identification possible. Even when taking precautions, people might be able to identify a friend, patient, or loved one. Written permission is essential; let the patient know that you will be writing a case report for publication with his or her consent.

The information about the patient is culled from the intake forms and treatment notes and summarized. Avoid describing the chain of events in order, session by session. Instead, present a comprehensive profile of the patient, and tell the story in a compelling manner, comparing pre- and postfindings and describing how your treatment plan unfolded.

Here is an example of a patient profile:

> The 76-year-old female, referred to for the purposes of this report as Sophia, was diagnosed with osteoarthritis of the hip in 2005. For over a decade, she has experienced pain, stiffness, and difficulty rising from a seated position. She continues to walk daily for exercise, play golf weekly, but has found these and other activities increasingly difficult. The physician referred her to an orthopedic surgeon 1 year ago, who recommended surgery, scheduled a year out.

As the surgery date approached, Sophia grew increasingly anxious. There was an urgent family need she wanted to attend to and a trip to Europe scheduled in September to visit friends. She asked if massage could help delay her need for surgery, keeping the pain at tolerable levels, and keep her active throughout the coming 6 months. Her goal was to reschedule the surgery for late fall.

Sophia walks with a limp, exaggerated after rising from a seated position or after a long day on her feet. She uses a cane when going out for several hours, not relying on it completely, but uses it increasingly as she tires. She walks nine holes of the golf course weekly, pushing a cart that she can lean on as needed. Before beginning the intensive series of massage sessions, she had to cancel rounds of golf often due to pain. The pain was a dull, constant ache generating from her hip that occasionally became a sharp pain radiating down her thigh. Her sleep was disrupted often during the night, but was able to sleep for shorter periods of time, napping in the afternoons

Her doctor recommended a dose of over-the-counter anti-inflammatories that she took occasionally. She preferred homeopathic remedies—easier on her stomach—and took those regularly, including a topical homeopathic ointment for pain and inflammation that she rubbed on her hip and thigh twice daily.

Sophia had received massage sessions on an as-needed basis prior to setting the goal to delay surgery.

The second part of the Methods section, the treatment plan, details the selected massage and bodywork techniques and the assessment strategies, how and where they are applied, and the duration and frequency of sessions. Include the measurement tools, and whether data were collected before or after the massage sessions, and at what intervals.

Discuss your clinical reasoning process. How did you consider the literature, what types of experience or training have you had with this condition, and how did you take into account the wishes of the patient? The selections should be supported in the literature, and if not, a rationale is expected.

Describe how the patient's feedback influenced the treatment plan, as well as how data collected with the measurement tools contributed to your session planning. Did you modify your plan, choosing different techniques to better accomplish your goals? Did you evaluate the effectiveness of your treatment choices based on how the tissue responded during the session as well as in between sessions? It is important to accurately represent what occurs in a massage session; flexibility within a treatment plan is common.

A descriptive case report gives a detailed account of the chosen subject. The topic may be the methods you use to examine a patient. Rather than focusing on one patient, you can describe your general approach—interview, intake forms, postural analysis, movement tests, and palpation tests. Include how you determine which assessments to select for a given condition or situation.

The Methods section describes all the details of the case except the results. Be thorough.

RESULTS

The Results section presents data in an organized fashion: charts, graphs or tables, with captions and legends. It includes numerical data, such as range of motion results, pain levels, or disability indices (quantitative data), and verbal reports from the patient, describing thoughts and feelings (qualitative data). This information is collected periodically, over

the course of treatment, according to a predetermined schedule. If any changes were made to the treatment plan once the course of care began, describe them in this section and provide the rationale.

In the case of Sophia, a 0–10 verbal analog scale was used to measure both pain and activities of daily living. 0 denotes no pain on the pain scale with 10 representing unbearable pain. The scale is reversed for function, to represent the desire for function to increase with improvement, while pain should decrease with care. Therefore, fully functional is represented by a 10 on the function scale, and complete loss of function (bedridden) is a 0. To fill in the gaps between 0 and 10 and to assist Sophia in selecting a number that best represented her pain or loss of function, the descriptive scale presented in Chapter 6, Documentation: Session Notes, was used and should be described in the report:

- 1, 2, 3 is used to denote pain that does not interfere in any way with activities of daily living.
- 4, 5, 6 is used to denote pain that forces one to modify activities of daily living, such as walking slower, shorter distances, sitting down to rest more frequently, etc. The more activities are modified, the higher the number.
- 7, 8, 9 is used to denote pain that forces one to omit activities from everyday life that were previously integrated, such as exercise, housework, self-care, or specific work responsibilities. The more activities omitted, the higher the number.

Similar descriptions are used for activities, in the opposite direction.

- 9, 8, 7 are used to identify when there is discomfort with some activities.
- 6, 5, 4 are used to identify when there are activities that must be modified or limited
- 3, 2, 1 are used when there are activities that must be avoided completely or simply cannot be performed.

Measures were taken and recorded at the beginning of each massage session, representing Sophia's current state in the moment. Inquiries were made regarding her pain and function in between sessions as well, and typically represented how she felt on the golf course that week, and if she was able to walk the nine holes. In addition, qualitative comments were recorded regarding her daily walks, how long she walked, the path she took (hilly or flat), and how she felt during and after her walks. Also recorded were her comments on how the massages were affecting her ability to exercise, be present for her daughter who was undergoing surgery, and her feelings about her upcoming trip to Europe.

The following figures graph her pain and activities and chart her comments (Figures 10-3, 10-4, and 10-5). The benefits of using an electronic charting system are twofold: the system prompts you to collect the data as often as every session, and the data automatically populate graphs and chart the progress for you.

A descriptive case report does not measure outcomes nor present results, thereby eliminating the need for this section.

DISCUSSION/CONCLUSION

Discussions/conclusions provide meaning to the results. Explain the effects of treatment, how they support or refute the hypothesis, and suggest implications to the profession.

Most importantly, tell it like it is, and avoid exaggerating outcomes or conclusions. Unfounded claims diminish the impact of the report. It is more respectable to identify your shortcomings and inform future research than to overstate your results. Be measured in your assertions, be open to alternative possibilities, and recognize the limitations of the project.

FIGURE 10-3. Electronic Health Record Pain Graph

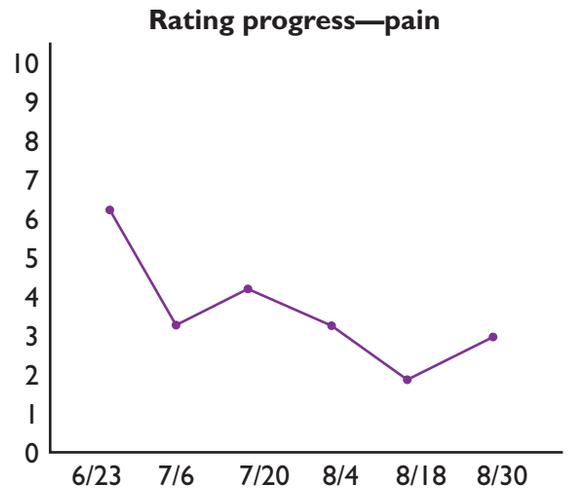
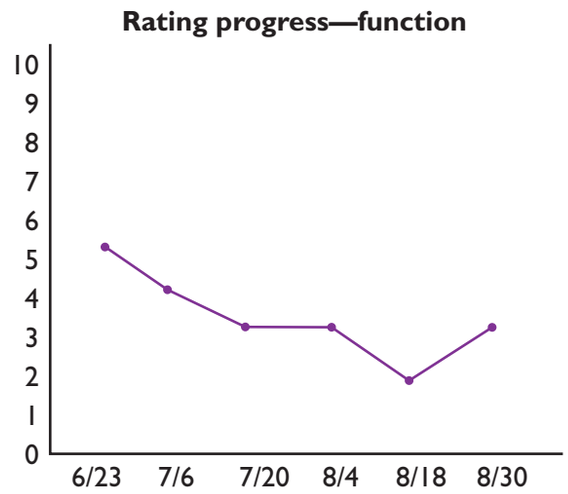


FIGURE 10-4. Electronic Health Record Activity Graph



In the ongoing example, Sophia was not only able to delay her surgery for 6 months, but the patient also chose to wait until the following fall to have surgery. Although the case report does not follow her into the next year, it is appropriate to say that her goal was met and the surgery was delayed for an undetermined length of time beyond the goal. Here it is important to speak to the outcomes: which techniques the patient felt most helpful and why, and if the immediately preceding activity influenced the outcome measures each session. If Sophia came in immediately following the round of golf, for example, her pain level was higher than if she had been resting that morning, but less than if she had come from playing bridge. Sitting was more problematic for Sophia than walking, an important bit of information to share in this section.

Although her pain levels were fairly consistent, which might be construed as no improvement, she remained very active. The Discussion section is the opportunity to shed light on the meaning behind the numbers, allowing the author to explain the meaning behind the data. It is also important to interject that the stress of Sophia's daughter's

FIGURE 10-5. Comments Chart

Activity	Comments	
	Pain levels	Abilities
Golf: walking 9 holes 1-2 X/wk	• Before, I didn't want to make tee times with friends in case the pain was too great and I'd have to cancel. • I can lean on my cart when the pain is rough, but I do not have to quit. • My swing is smoother, too, now that my hip pain is less.	• Massage every week is making the difference between walking and having to ride in a cart. • I am so happy to be out on the course, breathing fresh air, and playing with friends. • My handicap is dropping!
Walking in neighborhood	• With less pain in my hip I am relying on my cane less and less. • I always thought I just needed better shoes, but with the massages every week, my feet do not hurt. • I find myself listening to the birds instead of focusing on my pain.	• I feel so good I find myself doubling back and taking another loop before heading home. • Hills no longer make me nervous. I can get up and down without loosing my balance or feeling too much pain.
Sitting while playing bridge	• I continue to struggle with the pain when I get up from sitting after a few hours of bridge. • If I walk around for a few minutes, I can relieve the pain in my hips. • I am going to bring a pillow to sit on; the pain is really bad after sitting.	• I can't seem to find a position or a chair that doesn't make me hurt when I get up from sitting for long periods of time. I'll just get up more often. • It is the plane flight to Europe I worry about the most.

surgery caused a spike in her pain level and limited her activities that week. Her quantitative comments are also effective in adding meaning, expressing her belief that massage helped her remain active and kept her pain at tolerable levels.

Identify limitations to the study—what you learned that you might do differently next time or recommend that someone else consider in the future. For example, ankle swelling may have been reduced as reported by the client, but no measurements were taken and therefore cannot be objectively accounted for. A recommendation can be made to include this assessment in future studies.

In this example, Sophia started yoga in the middle of the course of treatments. It is important to discuss this as a possible limitation: a standardized research study attempts to control for and prevent the addition of treatments not provided from the start of the project. In this case, yoga is information that may contribute to understanding the outcomes and suggests potential variation for future treatments. Perhaps the successful outcome could be more directly attributed to the massage sessions had the patient not added another healing discipline into the mix. Or, if the pain-relieving trigger point massage to the psoas had been applied earlier in the treatment instead of during the last 2 weeks, perhaps the pain levels would have been reduced throughout. The inherent limitation is that this is a case report, a one-on-one series of sessions that are not generalizable to a larger population, and lacks controls on the content and quantity of interventions.

The primary outcome to discuss is whether the results are significant or compelling enough to recommend that a larger study be conducted. This is also possible if you present a hypothesis that has not yet been tested.

REFERENCES

The Reference section is the final section of a case report and lists the citations of all materials used to inform the study: research papers, textbooks, Web sites, etc. A prime purpose of a citation is intellectual honesty: to attribute to other authors the ideas they have previously expressed, rather than give the appearance that the ideas presented in the paper are the author's original thoughts. It is perfectly acceptable to incorporate the ideas, theories, and work of others; in fact, it is expected and encouraged. But the worst offense in academia is to pass an idea off as one's own when it is the intellectual property of another's.

There are several generally accepted citations systems, such as Harvard referencing, Modern Language Association style (MLA), American Sociological Association (ASA), American Psychological Association (APA), The Chicago Manual Style, and others. Each of these citation systems should be chosen relative to the needs of the type of publication being crafted. Editors will often specify the citation system to use.[31]

Citation content will vary depending on the type of source and the specific requirements of the publication:

- Journal: author(s), article title, journal title, date of publication, page numbers
- Book: author(s), book title, publisher, date of publication, page numbers
- Web site: author(s), publication title when available, the url, a date when the Web site was accessed.

Select a style that is comprehensive and detailed, knowing that you may have to alter the style according the publishing requirements of the journal when you submit your report. Or, if you have selected the journal you will submit to, use the required style. The MTF case report contest requires APA referencing, for example. As you conduct your literature search, cut and paste citations into a word document for future reference, or if you have saved the articles onto your computer, write the author and year into your report—for example: (LeMoon, 2008)—following the quote, making it easier to sequentially add the full citations to the Reference section later. Some referencing styles will require the last name and year of publication to be listed within the body of the report as in the example above (LeMoon, 2008). Other times you may have to convert it to a superscripted number.[23] In both instances, the complete citation will be listed at the end of the article. Rarely are footnotes used, as there are too many citations per page to make this style effective in a scientific paper.

Getting Published

Get your case report published in an academic or scientific, peer-reviewed, indexed journal. This is the only way to share our stories beyond the limited audiences of our clinics, schools, and trade magazines, and get them into a database where they will be acknowledged as medical research and accessible to health care professionals, researchers, and policy-makers.

Publishing adds value. Editing, production, marketing, and distribution are brought together by the publisher. The publisher provides in its name a guarantee of quality, which the reader may recognize; the journal is an envelope for the individual articles.[32]

Peer-reviewed journals require an extensive review process beyond copy-editing for grammar. Experienced clinicians and researchers are asked to pore over your report—checking your citations, and evaluating the depth of investigation, the accuracy of the reporting, and the impact of your findings. The journal editors ensure academic rigor is applied to the review process, verifying that the report meets the grade.

Databases compile published articles and provide systematic listings and search systems that permit access using identified terminology or key words. Journals are required to meet certain standards before the articles they publish will be accepted into the database and made accessible. A journal that has met the requirements and received approval for their content is "indexed" and all the articles therein, including previously published content, will be searchable on the database.

There are two journals that primarily publish massage and bodywork research: the *International Journal of Therapeutic Massage and Bodywork* (ijtmb.org) and the *Journal of*

Bodywork and Movement Therapies (elsevier.com/jbmt). Both are indexed, peer-reviewed, scientific journals. Submission criteria are outlined on the Web sites. Follow the guidelines, adjusting your case report as needed, and submit—electronically.

Other CIHC journals publish massage research occasionally. CIHC and biomedical journals are more likely to publish RCTs on massage therapy, rarely case reports. But you may want to consider these, opting for a higher profile for your paper. Here are some of the CIHC journals to consider: *Alternative Therapies in Health and Medicine*, *BMC Complementary and Alternative Medicine*, *Complementary Therapies in Clinical Practice*, *Integrative Cancer Therapies*, and the *Journal of Alternative and Complementary Medicine*.

A preliminary step to publishing is to submit your case report to the MTF Case Report Contest. A committee of researchers and advanced practitioners review the reports, and if you place in the top three, detailed feedback is provided and prizes are awarded. Support is available, should you choose to submit it for publication, and cash prizes follow if you are selected for publication.

The MTF case report contest provides educational videos and publishes extensive guidelines that can be downloaded as a pdf file. In addition to the guidelines on writing a case report, the online appendices include suggested reading, additional information on literature searches, a sample patient consent form, a sample photo release form, HIPAA guidelines, and a handy checklist.[33] Regardless of whether you submit your case report to the contest, review the guidelines and strengthen your understanding of writing a case report.

Read case reports that have been successfully published. Many are available at the MTF Web site.

REFINE YOUR SKILLS

Conduct Your Own Case Report Contest

In class or with your networking group, conduct a case report contest. It may be more fun to do it in small groups. It is easiest if done as a retrospective report. As a small group, select a patient from student clinic, or from one of your practices. Conduct a literature search on his or her condition. Once the data are compiled, assign different sections to each individual. The treatment part of the Methods section should be written by the patient's practitioner.

When complete, switch reports with another group. Peer-review each other's papers, writing down comments and suggestions for revision. Once each group has had at least one chance to rewrite the paper, submit them to the instructor or to an outside peer. The papers can be graded, using the point system found in the MTF case report guidelines. The winner may be rewarded by getting published in the school paper, submitted to the local chapter newsletter, or thrown a party!

SUBMISSION GUIDELINES

Publication guidelines range from font type and size, word counts, to language specifications (English only, for example), section headings, and reference styles. Some journals require presubmission inquiries—a cover letter that addresses the nature of your report and its significance for the field, with the abstract attached.

Publishing guidelines will be found on the journal's Web site. For *The International Journal of Therapeutic Massage and Bodywork* go to http://www.ijtmb.org/index.php/ijtmb. For submission to the MTF's case report contest, go to the Web site: http://mtf.amtamassage.org/grants-and-contests/case-report-contest.

REVIEW PROCESS

Once the report is submitted to the journal, usually through an online submissions process, the editorial board of a journal organizes a peer review and makes acceptance decisions. An in-house person is responsible for copy-editing the manuscript and the layout after the peer-review process is complete.

Peer review is central to the editorial function, ensuring the quality and reputation of the journal, and that the publisher is doing its best to serve science. The paper is critiqued by two or more researchers or advanced practitioners, the work of whom is usually unpaid. It is an excepted responsibility of those who submit research to in turn become a reviewer as they become skilled.

Reviewers are asked to assess the technical and scientific merits of the work. This process ensures the paper is fit for publication and will withstand critique by readers, including scientists, physicians, and the like. Comments from the reviewers are extensive and often the request is made for an extensive rewrite before recommending that the publisher accept the report. The author receives the comments and considers how to best incorporate or refute the input, and resubmits the manuscript for additional review until accepted or rejected.

The MTF contest can provide the support necessary to brave the critique. Writing a case report is challenging enough. Going through the publication process can be downright intimidating. Although it can be a humbling experience, it is most certainly an educational opportunity for all and well worth the effort. Those who persevere will be rewarded, financially, socially, and professionally.

Here's some encouragement from Glenda Keller, the 2009 MTF practitioner case report contest winner: "For me, doing a case study is a wonderful opportunity to further the massage therapy profession. I love being able to research a client's condition and expand on my knowledge. Most importantly, if the treatments are successful, it is very rewarding and satisfying to help the client. More people doing research would benefit the massage therapy field, and I love contributing to that research. I encourage everyone to try it!"[33]

Summary

Evidence-informed practice is an expectation of CIHC and biomedical HCPs alike. The institution of evidence-informed practice promotes a three-pronged approach to treatment planning that takes into consideration all the components of clinical reasoning. A health care practitioner formulates meaning, goals, and strategies by combining:

- current available research data
- practitioner experience and judgment
- patient preferences and presenting factors.

To become skilled at this level of clinical reasoning, one must obtain some level of research literacy. Research literacy is about mastering the skill of locating the research

through literature searches on medical databases, critically analyzing the data, and translating or converting the data into knowledge that contributes to clinical practices.

Translational research is also about sharing clinical experiences with the researchers to help advance studies that are meaningful to the practitioners and thereby the consumers. Case Reports are a great way to describe clinical interventions and share the issues practitioners face on a daily basis.

There are three presentation styles for writing case reports:

- Educational case reports illustrate common situations and are used to establish a baseline for practices.
- Assessment case reports describe and discuss analytical methods used to evaluate a client with uncommon conditions.
- Treatment or management style case reports are most common. A treatment-focused report follows a client through a session or series of sessions and describes everything from the client profile to the treatment outcomes.

All three styles of case reports can be written from either a prospective or retrospective approach. Prospective reports are conducted in real time. The patient is selected; the literature search is done in advance and informs the treatment plan and measurement tools. Retrospective reports are identified and compiled after the sessions have been completed. Retrospective reports require the consistent use of measurements tools and clear chart notes or progress reports that describe clinical reasoning and the methods of care provided.

The following structure is used when writing a case report:

- Title, Acknowledgements
- Abstract
- Introduction
- Methods
- Results
- Discussion/Conclusion
- References

Getting your case report published in an academic or scientific, peer-reviewed, indexed journal is the only way to share our stories outside the walls of our clinics, schools, and trade magazines and get them into a database where they will be acknowledged as medical research and accessible to health care professionals, researchers, and policy-makers. We have a responsibility to tell our stories, inform the research, and ensure our patients have access to intentional, educated touch as a part of their health and wellness care.

References

1. Çakici N, Fakkel TM, van Neck JW, Verhagen AP, Coert JH. Systematic review of treatments for diabetic peripheral neuropathy. *Diabet Med*. 2016;33(11):1466-1476. doi:10.1111/dme.13083.
2. Castro-Sánchez AM, Moreno-Lorenzo C, Matarán-Peñarrocha GA, Feriche-Fernández-Castanys B, Granados-Gámez G, Quesada-Rubio JM. Connective tissue reflex massage for type 2 diabetic patients with peripheral arterial disease: randomized controlled trial. *Evid Based Complement Alternat Med*. 2011;2011:804321.

3. Derry S, Rice AS, Cole P, Tan T, Moore RA. Topical capsaicin (high concentration) for chronic neuropathic pain in adults. *Cochrane Database Syst Rev*. 2017;1:CD007393. doi:10.1002/14651858.CD007393.pub4.
4. Hodgkinson GP, Langan-Fox J, Sadler-Smith E. Intuition: a fundamental bridging construct in the behavioral sciences. *Br J Psychol*. 2008;99:1-27.
5. Stopler E, Van Royen P, Van de Wiel M, et al. Consensus on gut feelings in general practice. *BioMed Central*. 2009;10:66.
6. LeMoon K. Clinical reasoning in massage therapy. *Int J Therap Massage Bodywork*. 2008;1:1.
7. Cano V. http://www.hospiweb.scotcit.ac.uk/lectures/purpose.shtml. Accessed October 10, 2010.
8. Menard MB. *Making Sense of Research*. 2nd ed. Toronto, Canada: Curties Overzet; 2009.
9. Rich J, ed. *Massage Therapy: Evidence for Practice*. Edinburgh, UK: Mosby; 2002.
10. http://www.ahc.umn.edu/cahcim/about/home.html. Accessed October 16, 2010.
11. http://nccam.nih.gov/about/plans/2010/. Accessed October 16, 2010.
12. http://www.prb.org/Publications/Media-Guides/2016/aging-unitedstates-fact-sheet.aspx.
13. Greenberg K. *Older Americans: 2008 Key Indicators of Well-Being*. Federal Interagency Forum on Aging-Related Statistics; 2008.
14. Barnes PM, Bloom B, Nahin RL. Complementary and Alternative Medicine Use Among Adults and Children: United States 2007, National Health Statistics Reports; no. 12, Hyattsville, MD: National Center for Health Statistics. AARP, NCCAM, Complementary and Alternative Medicine: What people 50 and older are using and discussing with their physicians. Consumer Survey Report; January 18, 2007. 2008.
15. http://www.pcori.org/about-us/our-story.
16. https://effectivehealthcare.ahrq.gov/index.cfm/what-is-comparative-effectiveness-research1/.
17. Crawford C, Boyd C, Paat CF, et al. The impact of massage therapy on function in pain populations—a systematic review and meta-analysis of randomized controlled trials: part I, patients experiencing pain in the general population. *Pain Med*. 2016;17:1-23.
18. Boyd C, Crawford C, Paat CF, et al. The impact of massage therapy on function in pain populations—a systematic review and meta-analysis of randomized controlled trials: part II, cancer pain populations. *Pain Med*. 2016;17:1553-1568.
19. Boyd C, Crawford C, Paat CF, et al. The impact of massage therapy on function in pain populations—a systematic review and meta-analysis of randomized controlled trials: part III, surgical pain populations. *Pain Med*. 2016;17:1757-1772.
20. http://www.massagetherapyfoundation.org/contest.html. Accessed October 10, 2010.
21. Jenkins D. What shall we do with case reports? *Br Med J*. 2008.
22. Vandenbroucke JP. In defense of case reports and case series. *Ann Intern Med*. 2001;134(4):330-334.
23. http://www.goomedic.com/medical-case-reports-report-your-case-solve-other-cases-interactive-medical-blogging.html. Accessed October 10, 2010.
24. A Profile of Older Americans: 2017. Administration on Aging (AoA), Administration for Community Living, U.S. Department of Health and Human Services.
25. Forestier R, Desfour H, Tessier J-M, et al. Spa therapy in the treatment of knee osteoarthritis, a large randomised multicentre trial. *Ann Rheum Dis*. 2009;69(4):660-605.
26. Reid MC, Papaleontiou M, Ong A, Breckman R, Wethington E, Pillemer K. Self-management strategies to reduce pain and improve function among older adults in community settings: a review of the evidence. *Pain Med*. 2009;9:4.

27. http://en.wikipedia.org/wiki/Institutional_review_board.
28. Panda M, Heath GW, Desbiens NA, Moffitt B. Research status of case reports for medical school institutional review boards. *J Am Med Assoc*. 2007;298(11):1277-1278.
29. http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.htm. Accessed October 16, 2010.
30. Perlman AI, Sabina A, Williams AL, Njike VY, Katz DL. Massage for osteoarthritis of the knee: a randomized controlled trial. *Arch Intern Med*. 2006;166:2533-2538.
31. http://en.wikipedia.org/wiki/Citation. Accessed October 16, 2010.
32. Guidelines for Scientific Publishing. Paris, France: ISCU Press, Committee on Dissemination of Scientific Information; 1999.
33. http://www.massagetherapyfoundation.org/practitionercontest.html. Accessed October 16, 2010.

Glossary

active listening: communication tool that demonstrates to the speaker that he or she is being understood and respected; nonverbal attendance to the speakers' tone, body language, facial expressions, and the like.

Advanced Billing Concepts (ABC) codes: comprehensive coding system that supports research, management, and commerce in the fields of alternative medicine, nursing, and other forms of integrative health care.

affinity plan, affinity network: contractual agreement between the provider and the network or carrier to provide a substantial discount directly to the members of the plan.

analog scale: method of measurement that uses a continuum and places one extreme on one end and the opposite extreme on the other end.

Any Willing Provider (AWP): statute that allows any provider willing to provide services to be accepted by the health carrier. The AWP law is currently in effect in Arkansas, Georgia, Idaho, Indiana, Illinois, Kentucky, Minnesota, Virginia, and Wyoming.

appeal: legal request for a higher court or reviewing body to review a decision made by a lower court or reviewing body regarding issues of law or policy, including denial of a claim.

at-fault party: individual who causes harm to another individual or damages property.

Attorney Lien: written agreement between patient and health care provider guaranteeing payment in full to the patient's health care providers upon settlement of a personal injury case; also known as *Guarantee of Payment.*

audit: a formal and often periodic examination of accounts, financial records, or claims to verify correctness of documentation.

body language: the nonverbal behavior of a person, including facial expressions, postures, gestures, and other actions; a primary means of emotional expression.

bundling: type of reimbursement arrangement that combines two or more health care procedures under one procedure code and establishes a flat fee to pay for all health care services performed under the single code; see *global fees.*

capitation: individual monthly payment made in advance to a managed care insurer for contracted services. The insurance provider agrees to provide specified services to eligible members at a fixed, predetermined payment during a specified period of time, regardless of how many times the member uses the services.

capped fee: predetermined discounted fee allowed for a particular procedure.

Centers for Disease Control and Prevention (CDC): a government agency who's mission is to collaborate to create the expertise, information, and tools that people and communities need to protect their health—through health promotion, prevention of disease, injury and disability, and preparedness for new health threats.

Centers for Medicare and Medicaid Services (CMS): a federal agency within the U.S. Department of Health and Human Services (HHS) responsible for programs such as Medicare, Medicaid, State Children's Health Insurance Program, HIPAA, and Clinical Laboratory Improvement Amendments; formerly, the Health Care Financing Administration (HCFA), which became CMS in 2001.

clean claim: insurance claim bill submitted with complete and accurate information for services that are covered for the patient and that the practitioner is authorized to provide.

CMS 1500 form: current standard billing form approved by federal and financing agencies; previously the HCFA 1500 form.

coinsurance: provision that the insured and the carrier share losses in agreed proportion; also known as *percent age participation*. In managed care, it refers to the portion of the cost of care for which the individual is responsible, usually determined by a fixed percentage. This often applies after a deductible is met.

complementary and alternative medicine (CAM), complementary and alternative health care (CAHC): medical and clinical services that typically are not taught at conventional medical institutions (also includes practitioners whose services are not typically covered by traditional insurance programs).

complimenting: communication tool used to reinforce behavior, such as a positive reaction or evaluation by the practitioner in response to the patient or a question that indirectly implies something positive about the patient.

co-pay: patient's share of a health care bill, usually a small amount per office visit.

Correct Coding Initiatives (CCI): pairs of CPT codes that cannot be used together in the same claim and is an attempt to control costs by preventing providers from unbundling services from one treatment session for reimbursement purposes.

covered entities: health care providers, health plans, or clearinghouses through which health information is transmitted electronically in connection with a HIPAA transaction.

Current Procedural Terminology (CPT) codes: descriptive terms and identifying codes for reporting health care services and procedures performed by health care providers.

deductible: part of the insured's expenses or loss that must be paid before the insurer begins to pay on a claim.

deposition: discovery procedure whereby the attorney calling for the deposition asks questions of witnesses and experts while the individuals are under oath.

disability percentage: overall rating of a physical handicap as determined by scoring the revised Oswestry Low Back Pain and Disability Index or the Vernon-Mior Neck Pain and Disability Index.

discharge SOAP notes: final summary of the patient's progress, health status, and subsequent course of action to be taken.

disclosure: release, transfer, provision of, access to, or divulgence of information by an entity to persons or organizations outside that entity.

discounted fee: reimbursement arrangement in which an insurance carrier contracts with a provider for health care services at a predetermined and often considerably lower fee.

door openers: communication tool used as an invitation to talk; open-ended questions.

electronic transactions, covered transactions: electronic exchanges of information between two covered entities using HIPAA-defined electronic data interchange transaction standards.

end-of-settlement: personal injury case in which the provider of health services must wait until the claim against the at-fault party is settled or a judge or jury issues a verdict before receiving payment for services.

Every Category of Provider (ECP): nondiscrimination statute that requires health insurance carriers to allow different provider categories to compete to provide services within their scope to perform and allows every insured access to the category of provider of his or her choice. The ECP law is currently only in effect in the state of Washington.

Explanation of Benefits (EOB): report from an insurance company to the patient and provider explaining the benefits paid, reduced, or denied.

fee schedules: maximum allowable charges; amounts set by the insurer as the highest amounts to be charged for particular services.

fee-for-service plans: traditional payment method in the U.S. health care industry in which patients pay doctors, hospitals, and other providers for services rendered at the time of service (and are charged according to a fee schedule set for each service or procedure provided). Typically, the patient seeks reimbursement for those costs from a private insurer or government program, such as Medicare.

following skills: communication tools, usually open-ended questions, used to discover how a patient views a situation, including how he or she feels about something in life, how he or she views an event, and who or what the patient feels is important.

functional goals: short-term and long-term goals for health based on daily activities that the patient is having difficulty performing.

functional outcomes: goals for which a client's progress toward improved health creates an increased ability to participate in daily activities.

functional outcomes reporting: style of charting that addresses (1) client's ability to function in everyday activities, (2) goal setting, and (3) treatment design to improve function and motivate increased client participation.

functional rating index (FRI): a self-reporting instrument consisting of 10 items, each with five possible responses that express graduating degrees of disability. The Functional Rating Index combines the concepts of the Oswestry Low Back Disability Questionnaire and the Vernon-Mior Neck Disability Index and seeks to improve on clinical utility, such as the time required for administration.

global fee: type of reimbursement arrangement that combines two or more health care procedures under one procedure code and establishes a flat fee to pay for all health care services performed under the single code; see *bundling*.

good faith provisions: requirements that insurers address matters with their insured members to satisfy the obligations of a contract, regulation, or law.

Health Care Financing Administration (HCFA): formerly the U.S. Department of Health and Human Services that administers federal health financing and related regulatory programs, principally Medicare, Medicaid, and Peer Review Organization programs, now known as the Centers for Medicare and Medicaid Services (CMS).

health care lien: health care provider's legal claim or lien on the patient's personal injury claim intended to guarantee that the provider's bills will be paid once the case is settled.

Health Insurance Portability and Accountability Act (HIPAA): legislation that provides rights, protections, and assurances of portability and continuity of health coverage to participants in group health plans.

Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification: Title II, Subtitle F that gives the U.S. Department of Health and Human Services the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information.

Health Maintenance Organizations (HMOs): legal entities that provide health care in a geographic area and accepts responsibility for providing (directly or by contract) an agreed-upon set of health services to a defined, voluntarily enrolled group of individuals. HMOs are reimbursed through a pre-determined, fixed, periodic prepayment made by or on behalf of each subscriber without regard to the amount of actual services provided. In many states, HMOs are synonymous with managed care.

hold harmless clause: legal concept commonly used among insurance carriers and in managed care contracts whereby the HMO and its providers do not hold one another liable for malpractice or corporate malfeasance if the other is found liable in a dispute. State laws require such a clause for the purpose of prohibiting health care providers from billing patients if the managed care company becomes insolvent.

ICD-10 codes: acronym for International Classification of Diseases, Tenth Revision; a statistical classification system that arranges diseases and injuries into groups according to established criteria (revised approximately every 10 years by the World Health Organization and published annually by the Health Care Financing Administration).

incidental use and disclosure: permissible use or disclosure of protected health information (PHI), such as announcing a name in a waiting room or having a sign-in sheet at the front desk. Sign-in sheets may not contain any PHI other than the patient's name.

indemnity plans: insurance plans that provide benefits paid to the insured at a predetermined amount in the event of a covered loss (automobile insurance policies are based on indemnity principles).

independent practice arrangement (IPA): HMO contract with a physician organization that, in turn, contracts with individual physicians to provide health services to its members. IPA physicians practice in their own offices and see fee-for-service patients. The IPA is reimbursed on a capitated basis and may reimburse its physicians on a capitated or modified fee-for-service basis when physicians charge agreed-upon rates to the HMO patients, then bill the IPA.

initial reports: summaries following the first visit (written in letter format) of the findings and plan for treatment.

initial SOAP notes: comprehensive notes recording the patient's first visit with a practitioner for a particular condition, including exam, findings, treatment, and treatment plan regarding the patient's health and current situation.

insurance companies: for-profit businesses primarily engaged in selling indemnification policies to individuals or groups to cover a defined set of benefits in the event of a loss.

insurance medical exam (IME), independent medical exam: examination of a patient, his or her health care records, or both; often used in personal injury cases to determine reasonable and necessary care and to support the insurer's decision to deny, limit, or terminate an insured's health benefits.

insurance network: company that contracts with two or more independent group practices or solo practices to provide health services to various insurance carriers' members.

insurance plan, insurance policy: specific benefit package offered by an insurer.

insured, member: party to an insurance agreement to whom, or on behalf of whom, the insurance company agrees to indemnify for losses, provide insurance benefits, or render service (preferred to *policyholder*). In prepaid hospital service plans, the insured is called the *subscriber*.

integrative health care or integrative medicine (IM), as developed and refined by the Consortium of Academic Health Centers for Integrative Medicine (CAHCIM), is the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals, and disciplines to achieve optimal health and healing.

liability coverage: insurance plan that pays for and renders service on behalf of an insured for loss resulting from the insured's negligence toward others as imposed by law or assumed by contract.

lives: number of insureds in a given area.

major medical: type of health insurance that provides benefits for most types of medical expenses incurred up to a high limit and expenses that occur in and out of the hospital—often subject to a large deductible.

managed care: philosophy of health care coverage that streamlines health services and creates a health care system that includes both the financing and delivery of services to the consumer. It also assumes greater responsibility for maintaining subscribers' health beyond just curing them once they are sick. Managed care lowers costs by matching the patient with appropriate care as efficiently as possible. Different insurance carriers use different kinds of managed care and often are differentiated by their reimbursement methods.

manual therapists: health care providers, such as massage therapists, chiropractors, physical therapists, and somatic educators who primarily rely on a manual means of providing health care services.

maximum benefit: limit of benefits paid to the injured party.

Medicaid: state program that provides public assistance to persons, regardless of age, whose incomes and resources are insufficient to pay for health care.

medical necessity, medically necessary: terms referring to health care services that, in order to be covered by insurance, are performed in order to preserve the health status of a patient in accordance with the area's standards of medical practice.

Medical Payments (MedPay) coverage: insurance provision that allows benefits to be paid for medical expenses.

medicare: federal hospital insurance system and supplementary medical insurance coverage for the aged; created in 1965 by an amendment to the Social Security Act.

morning pages: practice of writing three pages each morning of "whatever comes to mind."

narrative reports: summaries written in letter form of a patient's injuries, treatment, and progress throughout the entire course of treatment.

National Correct Coding Initiatives (NCCI): pairs of CPT codes that cannot be used together in the same claim and is an attempt to control costs by preventing providers from unbundling services from one treatment session for reimbursement purposes.

network adequacy: basis upon which a carrier determines the number of providers necessary to provide services to the lives. The formula used considers a combination of the number of lives within a geographic location and time and distance traveled to the provider. Requirements are determined by the insurer and available to the Department of Insurance.

no-fault: insurance benefits provided regardless of responsibility or liability of party.

Notice of Privacy Practices (NPP): legal document stating the actions and policies a given practice will provide to protect its patients' rights (developed by the individual health care practice and its legal counsel).

Office for Civil Rights (OCR): enforcement agency for the HIPAA Privacy Rule.

peer review: mechanism to control health care utilization and quality of care; an internal peer-review process used to evaluate the quality of care provided and to assess medical necessity.

personal injury: bodily injury resulting from the negligence of another person.

Personal Injury Protection (PIP) coverage: insurance provision that allows benefits to be paid for medical and hospital costs, loss of wages and services, and funeral expenses.

Physician's Desk Reference (PDR): resource manual of drugs and medications, including information on generic terms, doses, and side effects.

pre-existing conditions: injuries, illnesses, or symptoms that existed prior to the onset of the current injury or condition.

Preferred Provider Organizations (PPOs): companies that offer a health care arrangement between purchasers of health care, such as employers and insurance companies, and providers, to manage benefits and provide them at a reasonable cost and with incentives, such as lower deductibles and co-pays, to motivate members to use providers within a selected network. Use of out-of-network, or nonpreferred, providers involves higher costs. Preferred providers must agree to specified fee schedules and are required to comply with certain utilization and review guidelines.

preferred provider status: contracted, licensed, health care providers who provide specified health care services for a predetermined fee.

prescriptions: formal referrals for adjunctive services. Prescriptions infer medical necessity, provide patient information (such as diagnosis and ICD-9 codes), and define treatment parameters.

primary care: first care a patient receives, either from a family physician, nurse, paramedic, or other health care provider, depending on the situation (often the level at which managed care systems try to resolve health problems).

primary care status: health care providers who are authorized to manage a patient's care, as determined by individual health care programs; status is often limited to physicians, but may include naturopaths and nurses.

primary insurer: patient's main source of insurance coverage; the company primarily responsible for providing benefits.

Privacy Rule: HIPAA Administrative Simplification section mandating that information identifying a patient is to be protected and that the transmission of protected information is to be kept secure. The Privacy Rule includes safeguard measures to control the unauthorized disclosure of, access to, and use of protected health information (PHI) and grants patients six rights, including the right to gain access to and have more control over the use and disclosure of their PHI. The rule also requires personnel in medical practices to respect those rights.

private health insurance: insurance coverage against loss resulting from sickness or bodily injury.

problem-oriented medical record (POMR): documentation system, introduced by Dr. Lawrence Weed in the 1960s, that lists the patient's problems at the front of the chart and allows the practitioner to write a SOAP note to address each problem.

progress reports: summaries of patient progress and suggested additions or changes to the treatment plan submitted in letter format to the referring HCP every 30 days.

progress SOAP notes: comprehensive notes for recording reevaluation and reexamination sessions.

protected health information (PHI): information that can be used to identify an individual because it contains the patient's name, social security number, telephone number, zip code, email address, or other identifiers. The HIPAA Privacy Rule states that PHI must be protected whether it exists in written, spoken, or electronic form. Health information that has been stripped of patient identifiers is not considered PHI.

proximate cause: initial act that sets off a sequence of events that produces injury, which, in the absence of the initial act, would not have resulted.

quality improvement program: internal peer-review process used to audit the quality of care provided and often includes an educational mechanism to identify and prevent discrepancies in care.

range of motion (ROM): a movement test to access the available motion allowed by the shape of the joint and the soft tissue surrounding it.

reasonable and necessary: a standard insurance and legal term found in automobile and health care insurance policies governing the basis for paying or denying treatment claim expenses.

rebating :practice of accepting payment for referrals or referring to clinics.

referring health care providers (HCPs): health care providers who prescribe adjunctive care; often the primary care provider or provider with diagnostic scope authorized to manage the patients' health care.

reflecting: communication tool using parroting, paraphrasing, or summarizing the information and feelings the patient has expressed verbally or nonverbally.

Relative Value Unit (RVU): unit calculated and proposed by the AMA and refined and approved by the HCFA using RBRVS methodology.

resource-based relative value scale (RBRVS): process methodology developed at Harvard University to assess physician work, overhead cost, and malpractice risk for individual CPT codes.

Revised Oswestry Low Back Pain and Disability Index: type of pain questionnaire used to evaluate injuries to the low back and lower extremities.

scope of practice: law defining the standards of competence, practice areas, and conduct of a health care provider.

secondary insurer: insurance that becomes active after primary coverage is exhausted or expires.

self-care the patient's active participation in the healing process. Includes remedial exercise, hydrotherapy, self-message, diaphragmatic breathing, and referrals to other practitioners, self-help groups, or exercise programs.

self-insured, self-insurance practice of an employer or organization to assume the responsibility for health care losses of its employees. Usually, a fund is established and claims payments are drawn against it. Claims processing is often handled through an administrative services contract with an independent organization, usually an insurer.

silence: communication tool that allows a patient to sort out thoughts, take a short breather from the work at hand, or search deeper for answers to the practitioner's questions.

SMART goals: acronym for Specific, Measurable, Attainable, Relevant, Time-Bound; a system for creating well-defined functional goals.

SOAP charting: acronym for Subjective, Objective, Assessment, and Plan; a process for providing a standard health care format for charting and documenting treatment sessions. Information is organized into four categories: S, data provided by the client; O, practitioner findings; A, functional outcomes and diagnoses; and P, treatment recommendations.

statute of limitations, statutory time limits: provisions within laws that govern the time frame within which a lawsuit must be brought (otherwise the claim will be barred or dismissed); statutes of limitations differ from state to state and according to the nature of the claim.

stipulation: request for medical records containing the patient's and patient's attorney's consent to authorize release.

subpoena: court-ordered, written command requiring a person to appear at a specific time and place to give testimony on a specific matter. A *subpoena duces tecum* is a written command requiring a witness to produce documents in his or her possession or control that are pertinent to the issues.

subrogation: a legal principle that generally means that a patient cannot have the same bill paid twice.

subsequent SOAP notes: brief notes addressing the patient's immediate concerns for the day's session.

Team Therapy Model: paradigm for approaching the interview and information-gathering process; a combination of a medical model and intervention-free model of solution building.

third-party coverage: liability insurance coverage of the at-fault party or the uninsured/underinsured coverage of the patient.

treatment plan: formal description of how a patient will be treated; a list of functional goals and treatment goals, including the techniques, modalities, and specific ways that treatment will be applied, as well as the frequency and duration of treatment sessions and homework and self-care education.

unclean claims: insurance claim bills that lack information or contain disputable information.

uninsured motorist: component of automobile insurance coverage that protects an insured driver from losses that should be the responsibility of the other driver who is not carrying liability insurance to cover losses.

upcoding: fraudulent practice of increasing the value of a procedure code from lower to higher that results in a large reimbursement amount.

U.S. Department of Health and Human Services (HHS): the regulatory agency that implements HIPAA.

use and disclosure: refers to the sharing of protected health information inside a medical office (use) and the releasing, transferring, or accessing of protected information outside the medical office (disclosure).

usual, customary, and regular (UCR): refers to fees that health insurance plans will pay to a health care provider when deemed reasonable and do not exceed usual amounts customarily charged by local health care providers and others; also called *usual and customary.*

utilization: patterns of use of a service or type of service within a specified time. Usually expressed in rate per unit or population-at-risk for a given period. Utilization experience multiplied by the average cost per unit or service delivered equals capitated costs.

utilization management program: a systematic process to review and control patients' use of medical services and quality of care through data collection, review, or authorization, especially for services involving specialists and use of an emergency department or hospital.

Vernon-Mior Neck Pain and Disability Index: type of pain questionnaire used to evaluate injuries to the neck and upper extremities.

wellness charting: charting method for recording treatments and tracking results to create individualized, effective treatment plans.

workers' compensation: insurance coverage that includes medical and disability benefits for illnesses, injuries, disabilities, and death resulting from job-related conditions and activities (employers are mandated by law to purchase for all employees).

Index

Note: Page numbers followed by "f" indicate figures, "t" indicate tables, and "b" indicate boxes.