Back To Chiropractic CE Seminars

Work Comp: Billing & Coding ~ 4 Hours

Welcome to Back To Chiropractic Online CE exams:

This course counts toward your California Board of Chiropractic Examiners CE.
(also accepted in other states, check our website or with your Chiropractic State Board)

The California Board requires that you complete all of your CE hours BEFORE the end of your Birthday month. We recommend that you send your chiropractic license renewal form and fee in early to avoid any issues.

Exam Process: Please read all instructions before starting!

1. You must register/pay first. If you haven't, please return to: backtochiropractic.net
2. Open a new window or a new internet tab & drag it so it's side-by-side next to this page.
3. On the new window or new tab you just opened, go to: backtochiropractic.net website.
4. Go directly to the Online section. DON'T register again.
5. Click on the Exam for the course you want to take. No passwords needed.
6. Follow the Exam instructions.
7. Upon passing the exam you'll be able to immediately download your certificate, and it'll also be emailed to you. If you don't pass, you can repeat the exam at no charge.

Please retain the certificate for 4 years.
If you get audited and lose your records, I'll have a copy.

I'm always a phone call away... 707.972.0047 or email: marcusstrutzdc@gmail.com

Marcus Strutz, DC
Back To Chiropractic CE Seminars

Utilization Review in Workers' Compensation

Billing & Coding in WC!

GLENN CRAFTS, B.S., D.C., Q.M.E.

UTILIZATION REVIEW DIRECTOR

PRIVATE PRACTICE

Tel: (408) 691-4012 | Email: drcrafts@sbcglobal.net

Required Guidelines

- For accepted claims, The California Division of Workers' Compensation (DWC) requires that any treatment not authorized by the claims administrator, be sent to Utilization Review.
- Utilization Review must use mandated guidelines in rendering a medical necessity determination.
- The reviewer may only deviate from the mandated guidelines if they are "silent," or do not address the treatment being requested.

- MTUS - http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS/MTUS_Regulations.htm
- ACOEM – 2004, 2nd edition
- Official Disability Guidelines

Guidelines

8 CCR § 9792.25. Presumption of Correctness, Burden of Proof and Strength of Evidence.

(a) The MTUS is presumptively correct on the issue of extent and scope of medical treatment and diagnostic services addressed in the MTUS for the duration of the medical condition. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the schedule is reasonably required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof.

(b) For all conditions or injuries not addressed by the MTUS, authorized treatment and diagnostic services shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are nationally recognized by the medical community.

(c)(1) For conditions or injuries not addressed by either subdivisions (a) or (b) above; for medical treatment and diagnostic services at variance with both subdivisions (a) and (b) above; or where a recommended medical treatment or diagnostic service covered under subdivision (b) is at variance with another treatment guideline also covered under subdivision (b), the following ACOEM's strength of evidence rating methodology is adopted and incorporated as set forth below, and shall be used to evaluate scientifically based evidence published in peer-reviewed, nationally recognized journals to recommend specific medical treatment or diagnostic services:

Guidelines

- If MTUS applies to the injured worker's medical condition or illness, then:

- MTUS must be applied first, unless the treating physician has met the burden of proof to apply guidelines outside of the MTUS.

Chiropractic Guidelines by Body Part

- **Shoulder** (ODG) states 9 visits over 8 weeks.
- **Forearm, wrist, hand** (ODG) states despite not recommended, may allow for 9 visits over 8 weeks.
- **Knee** (ODG) states despite not recommended, may allow 12 visits over 8 weeks.
- **Ankle** (ODG) states despite not recommended, may allow 9 visits over 8 weeks.

Chiropractic Guidelines - ODG

- **Regional Neck Pain:**

9 visits over 8 weeks

- **Cervical Strain:**

Intensity & duration of care depend on severity of injury as indicated below, but not on causation. These guidelines apply to cervical strains, sprains, whiplash (WAD), acceleration/deceleration injuries, motor vehicle accidents (MVA), including auto, and other injuries whether at work or not. The primary criterion for continued treatment is patient response, as indicated below.

Mild (grade I - Quebec Task Force grades): up to 6 visits over 2-3 weeks

Moderate (grade II): Trial of 6 visits over 2-3 weeks

Moderate (grade II): With evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, avoid chronicity

Severe (grade III): Trial of 10 visits over 4-6 weeks

Severe (grade III): With evidence of objective functional improvement, total of up to 25 visits over 6 months, avoid chronicity

- **Cervical Nerve Root Compression with Radiculopathy:**

Patient selection based on previous chiropractic success --

Trial of 6 visits over 2-3 weeks

With evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, if acute, avoid chronicity and gradually fade the patient into active self-directed care

- **Post Laminectomy Syndrome:**

14-16 visits over 12 weeks

Functional Improvement

- The provider must prove and document "Functional Improvement" to the utilization review health care professional/nurse or physician reviewer in order to prove efficacy of treatment and to substantiate any additional care.

Functional Improvement

Section 9792.20 of the MTUS Medical Treatment Utilization Schedule-CA 2009 MTUS CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, p. 48

Functional improvement measures
Definitions:

- (f) "**Functional improvement**" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment.

- Recommended. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. It should include the following categories:

- Work Functions and/or Activities of Daily Living, Self Report of Disability (e.g., walking, driving, keyboard or lifting tolerance, Oswestry, pain scales, etc): Objective measures of the patient's functional performance in the clinic (e.g., able to lift 10 lbs floor to waist x 5 repetitions) are preferred, but this may include self-report of functional tolerance and can document the patient self-assessment of functional status through the use of questionnaires, pain scales, etc (Oswestry, DASH, VAS, etc.)

Non-Physician Reviewer

- A non-physician reviewer may be used to initially apply specified criteria to requests for authorization for medical services. A non-physician reviewer may approve/authorize requests for authorization of medical services.
- This is considered a first level review.
- Non-Physician reviewers are typically the claims examiners, or nurses.
- A Non-Physician reviewer may NEVER deny, or modify a treatment request.

The UR Determination

- The communication **by telephone** shall be **followed by written notice** to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours for concurrent review and within two business days for prospective review. For purposes of this section "normal business day" means a business day as defined in section 9 of the Civil Code.

- Note: 5:30 PST = End of Business Day (M-F)

Utilization Review Penalties/Fines

Penalty:	Fine	CCR
Not Attaching IMR Application form to URD	$2,000.00	(c)(1) For the failure to provide the Application for Independent Medical Review, DWC Form IMR, set forth at section 9792.10.2, with a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(l) or 9792.9.1: $2,000.
Records are not timely delivered to Maximus upon notice	<$5000.00	(6) For the failure to timely provide all information required by section 9792.10.5(a) and (c): $500.00 for each day the response is untimely up to a maximum of $5,000.00.

Utilization Review Penalties/Fines

Penalty:	**Concurrent**	**Prospective**	**Retrospective**
Not Responding to RFA	$2,000.00	$1,000.00	$500.00
Late Response to RFA	$100.00	$100.00	$100.00

DWC Form RFA

- Alternatively, CCR 9792.9.1(c)(2)(B)

- The ***claims administrator may accept a request for authorization for medical treatment that <u>does not</u> utilize the <u>DWC Form RFA</u>***, provided that:

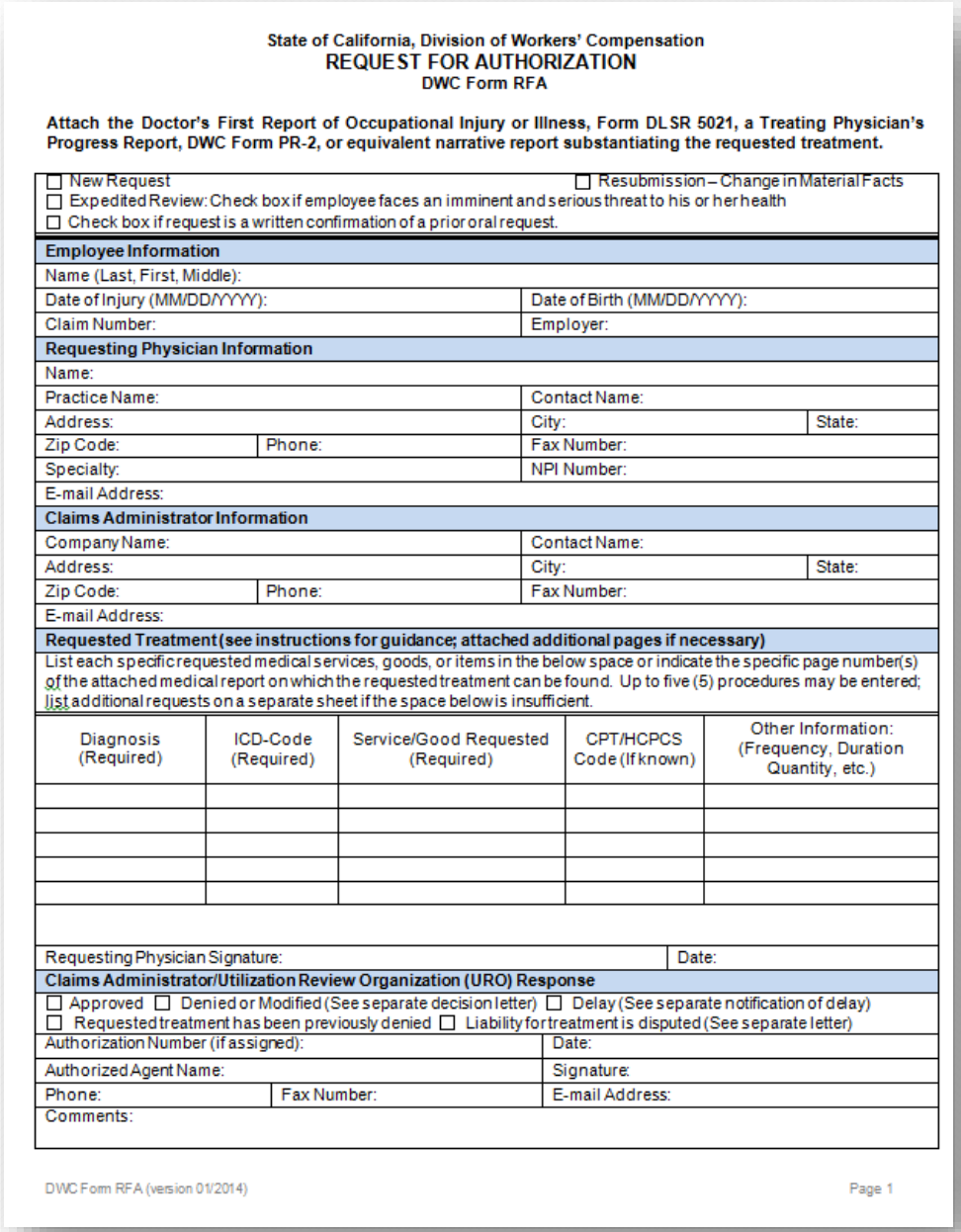
  (1) "Request for Authorization" is clearly written at the top of the first page of the document;

  (2) all requested medical services, goods, or items are listed on the first page; and

  (3) the request is accompanied by documentation substantiating the medical necessity for the requested treatment.

- **The claims administrator has the choice to go forward with an RFA or any document that is not complete, but most are now requiring the use of a DWC From RFA with all treatment requests.**

Complete the DWC Form RFA and attach to your treatment request every time.



State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☐ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information			
Name (Last, First, Middle):			
Date of Injury (MM/DD/YYYY):		Date of Birth (MM/DD/YYYY):	
Claim Number:		Employer:	
Requesting Physician Information			
Name:			
Practice Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
Specialty:		NPI Number:	
E-mail Address:			
Claims Administrator Information			
Company Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)

Requesting Physician Signature: Date:

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

DWC Form RFA (version 01/2014) Page 1

Expedited Treatment Requests

Expedited RFAs – 9792.9.1(c)(4)

- If an RFA is marked as "Expedited," it must be certified by the requesting physician. In other words, the requesting provider must justify/explain why the request for treatment is urgent and delaying the decision may be detrimental and/or cause imminent danger to the health/life of the injured worker.

- The requesting provider will mark the RFA as expedited by **checking the Expedited box** on the DWC form RFA.

Independent Bill Review
IBR *Fees ($)*

- Any IBR application submitted on or after January 1, 2015 will be subject to the following fee schedule:

- *Completed IBR*
  Fee effective April 1, 2014: $250 per IBR
  Fee effective Jan. 1, 2015: $195 per IBR

- *Ineligible IBR Not Sent to Review****
  Fee effective April 1, 2014: $50.00 per IBR
  Fee effective Jan. 1, 2015: $47.50 per IBR

- *** Sending an IBR to review means assigning and providing the complete file to a certified coding specialist with the expertise necessary to evaluate and render decisions on all line items in dispute.
- **IBR fees are paid by the contesting provider.**

PRINT CLEAR

State of California
Division of Workers' Compensation
Request for Independent Bill Review
California Code of Regulations, title 8, section 9792.5.8

Employee Information	
Employee Name (Last, First, Middle):	
Date of Injury (MM/DD/YYYY):	Claim Number:
Date of Birth (MM/DD/YYYY):	Employer Name:
Provider Information	
Provider Name:	Contact Name:
Address:	
Phone:	Fax Number:
E-mail Address:	NPI Number:
Provider Type: ☐ Ambulance ☐ Clinical Laboratory ☐ DMEPOS Supplier ☐ Inpatient Hospital ☐ Hospital Outpatient ☐ Interpreter ☐ Ambulatory Surgical Center ☐ Pharmacy ☐ Qualified Medical Evaluator ☐ Agreed Medical Evaluator ☐ Treating Physician ☐ Other Practitioner – specify:_____	
Provider Specialty:	
Claims Administrator Information	
Claims Administrator Name:	Contact Name:
Address:	
Phone:	Fax Number:
E-mail Address:	
Bill Information	
Applicable Fee Schedule(s): ☐ Physician Services ☐ Inpatient Hospital Services ☐ Hospital Outpatient Departments and Ambulatory Surgical Centers ☐ Pharmaceutical ☐ Pathology and Laboratory Services ☐ DMEPOS ☐ Ambulance Services ☐ Medical-Legal Fee Schedule ☐ Interpreter ☐ Other – specify:_____ Or: ☐ Contract for Reimbursement Rates	
Date of Second Bill Review Decision (MM/DD/YYYY):	Was Billed Service Authorized? ☐ Yes ☐ No
Date of Service (MM/DD/YYYY):	
Service/Good Code in Dispute (include modifier, if any):	
Amount Billed: / Amount Paid: / Amount in Dispute:	
Reason for Disputing Reduction or Denial of Full Payment:	
Consolidation	
Should the Request be Consolidated with Other Disputed Billed Services or Goods? ☐ Yes ☐ No	
Reason for Consolidation:	
Disputed Service/Good to be Consolidated (list all; use attachment if necessary):	
Date of Service (MM/DD/YYYY):	
Service/Good Code in Dispute (include modifier, if any):	
Amount Billed: / Amount Paid: / Amount in Dispute:	
Reason for Disputing Reduction or Denial of Full Payment:	
Documents to Accompany Request (Must be Indexed and Separated)	
The original billing itemization and original supporting documentation.	
The explanation of review provided in response to the original billing.	
The request for second bill review and original documentation supporting second review.	
The explanation of review provided in response to the second bill review request.	
If applicable, the relevant contract provisions for reimbursement rates.	
Provider Signature:	Date:
If mailed, send to: DWC-IBR c/o Maximus Federal Services, Inc., 625 Coolidge Drive, Suite 100, Folsom, CA 95630. Concurrently send a copy of this request to the Claims Administrator.	

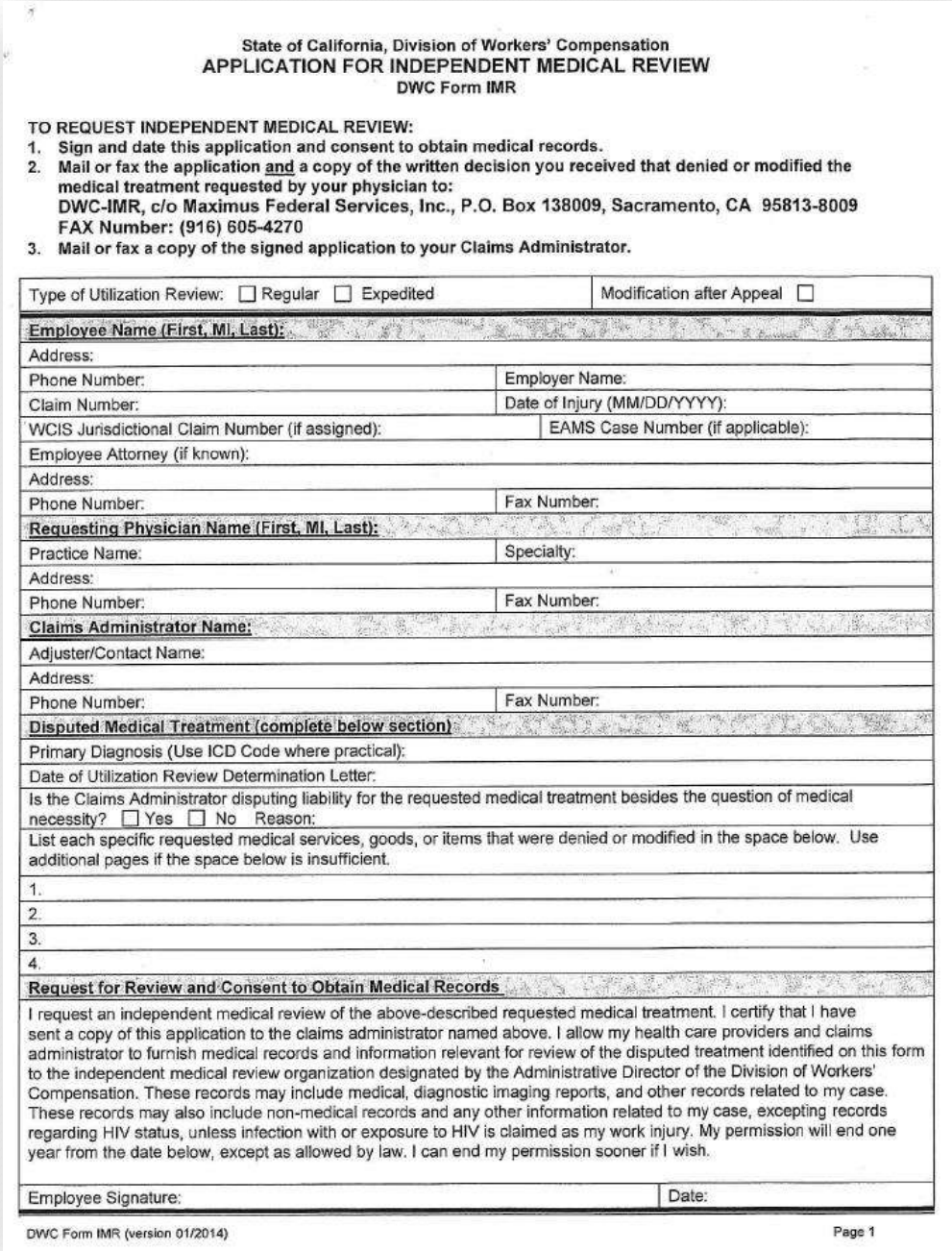
IMR Application Form

1. Check Box added for Modification after Appeal.

IMR Preclusions (IMR Application must be generated and attached to UR Determination letter)

Preclusions to IMR:

1. Disputed body part(s)/Causation.
2. IMR excluded for UR denials based on Lack of Information.
3. Untimely UR Decision (WCAB)/Dubon 2



State of California, Division of Workers' Compensation
APPLICATION FOR INDEPENDENT MEDICAL REVIEW
DWC Form IMR

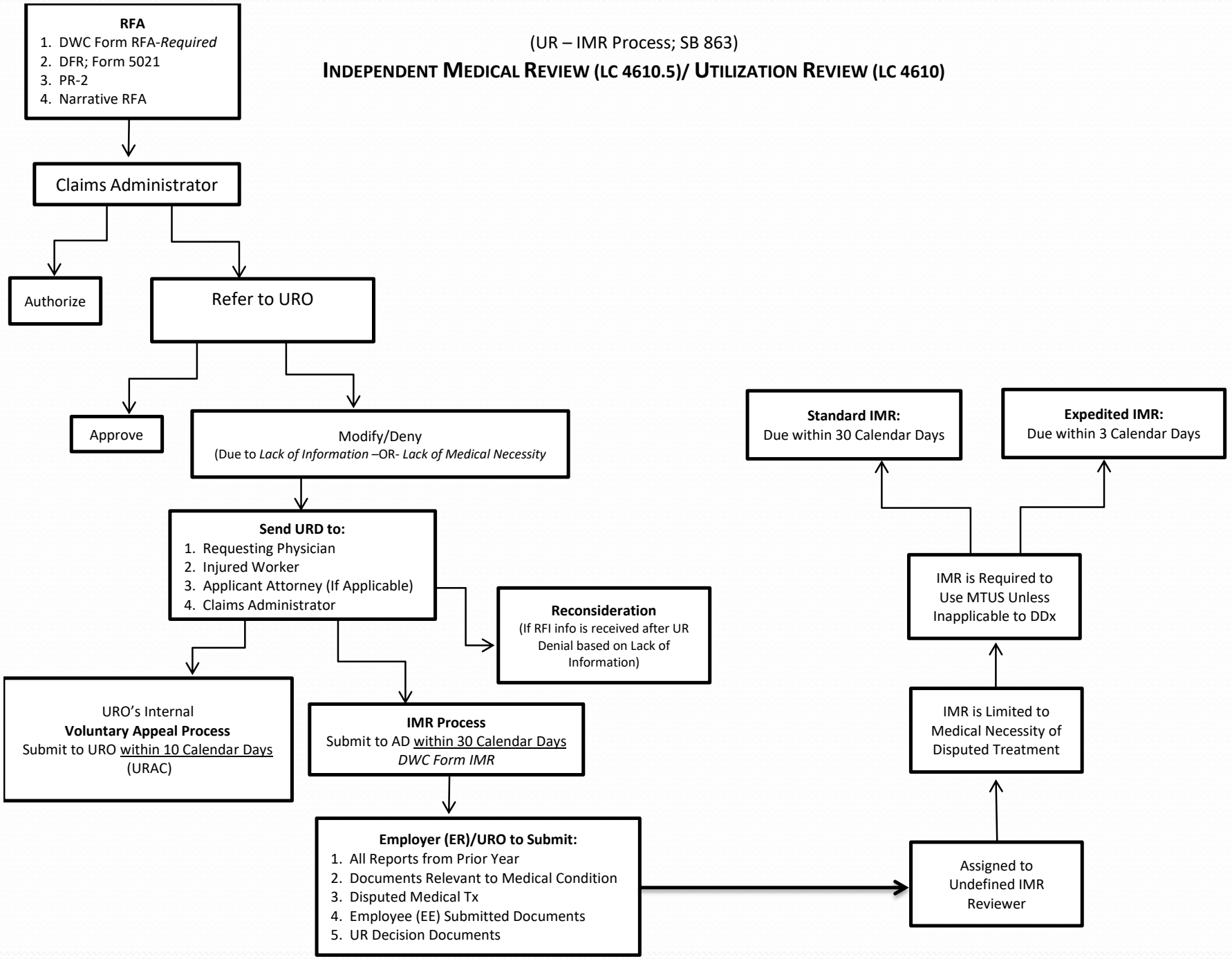
TO REQUEST INDEPENDENT MEDICAL REVIEW:
1. Sign and date this application and consent to obtain medical records.
2. Mail or fax the application and a copy of the written decision you received that denied or modified the medical treatment requested by your physician to:
   DWC-IMR, c/o Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
   FAX Number: (916) 605-4270
3. Mail or fax a copy of the signed application to your Claims Administrator.

Type of Utilization Review: ☐ Regular ☐ Expedited	Modification after Appeal ☐
Employee Name (First, MI, Last):	
Address:	
Phone Number:	Employer Name:
Claim Number:	Date of Injury (MM/DD/YYYY):
WCIS Jurisdictional Claim Number (if assigned):	EAMS Case Number (if applicable):
Employee Attorney (if known):	
Address:	
Phone Number:	Fax Number:
Requesting Physician Name (First, MI, Last):	
Practice Name:	Specialty:
Address:	
Phone Number:	Fax Number:
Claims Administrator Name:	
Adjuster/Contact Name:	
Address:	
Phone Number:	Fax Number:
Disputed Medical Treatment (complete below section)	
Primary Diagnosis (Use ICD Code where practical):	
Date of Utilization Review Determination Letter:	
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? ☐ Yes ☐ No Reason:	
List each specific requested medical services, goods, or items that were denied or modified in the space below. Use additional pages if the space below is insufficient.	
1.	
2.	
3.	
4.	
Request for Review and Consent to Obtain Medical Records	
I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the claims administrator named above. I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.	
Employee Signature:	Date:

DWC Form IMR (version 01/2014) Page 1

(UR – IMR Process; SB 863)

INDEPENDENT MEDICAL REVIEW (LC 4610.5)/ UTILIZATION REVIEW (LC 4610)



IBR & 2nd Bill Review Rights not Required on EOR

- 8 CCR §9792.5.5
- a) If the **provider disputes the amount of payment** made by the claims administrator on a bill for medical treatment services or goods rendered on or after January 1, 2013, submitted pursuant to Labor Code section 4603.2, or Labor Code section 4603.4, or bill for medical-legal expenses incurred on or after January 1, 2013, submitted pursuant to Labor Code section 4622, the **provider may request the claims administrator to conduct a second review of the bill.**
- (b) The second review **must be requested within 90 days** of:
- (B) The Request for Second Bill Review form, **DWC Form SBR-1**, set forth at section 9792.5.6. The DWC Form SBR-1 shall be the first page of the request for second review submitted by the provider.

IBR & 2nd Bill Review Rights not Required on EOR

- 8 CCR §9792.5.5
- (B) The **item and amount in dispute**.
- (C) The **additional payment requested and the reason** therefor.
- (D) The **additional information** provided in response to a request in the first explanation of review or any other additional information provided in support of the additional payment requested.
- (e) If the only dispute is the amount of payment and the **provider does not request a second review within the timeframes** set forth in subdivision (b), the **bill shall be deemed satisfied** and neither the claims administrator nor the employee shall be liable for any further payment.
- (g) **Within 14 days** of receipt of a request for second review that complies with the requirements of subdivision (d), the **claims administrator shall respond to the provider with a final written determination** on each of the items or amounts in dispute by issuing an explanation of review.
- (h) Based on the results of the second review, payment of any balance no longer in dispute, or payment of any additional amount determined to be **payable, shall be made within 21 days** of receipt of the request for second review. The 21-day time limit for payment may be extended by mutual written agreement between the provider and the claims administrator.
-
- (i) If the provider further contests the amount paid after receipt of the final written determination following a second review, the provider shall request an **independent bill review** pursuant to this Article.
- **If the IBR finds in favor of the provider, then the employer must reimburse the IBR fee.**

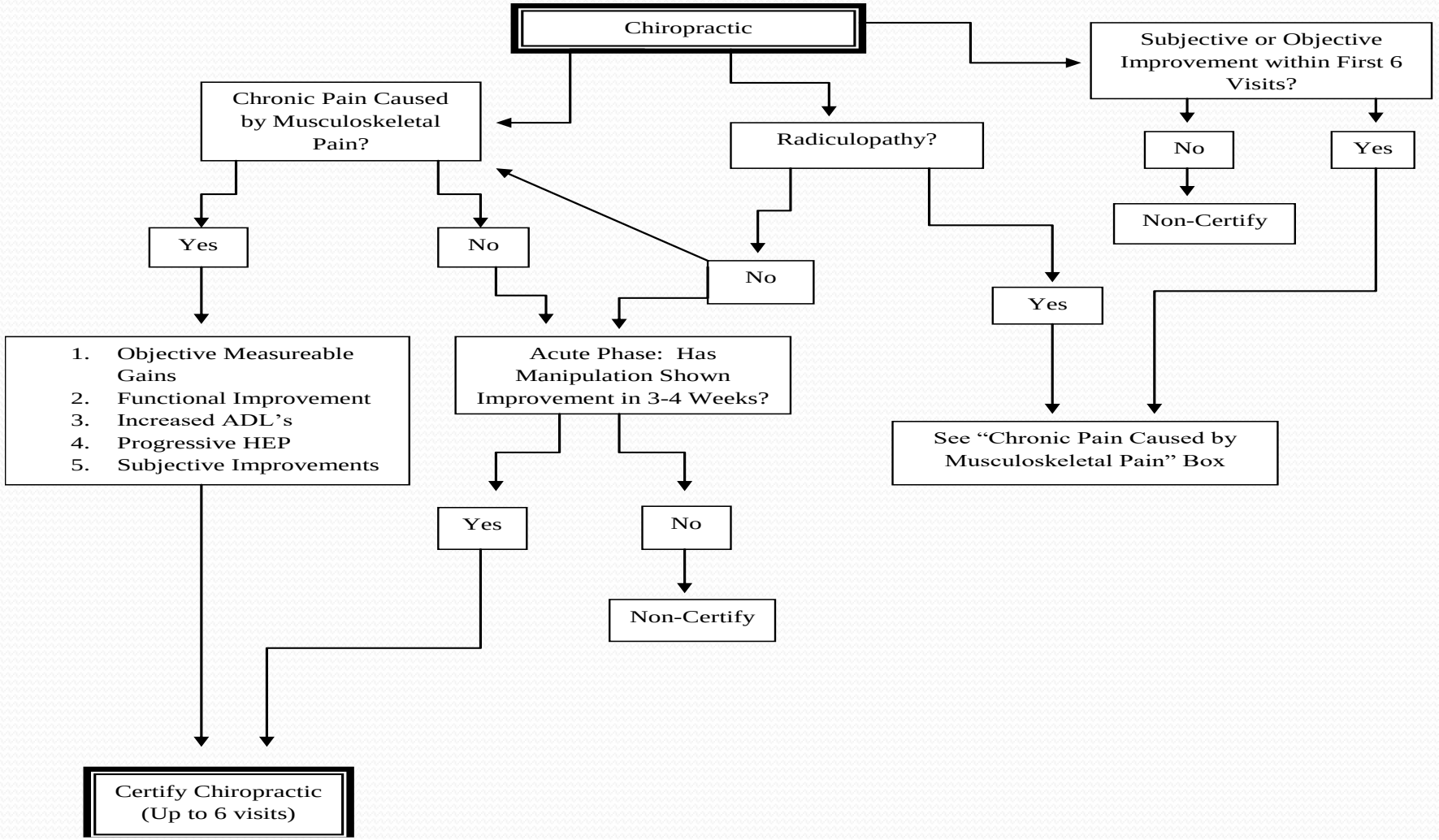
Key UR Changes

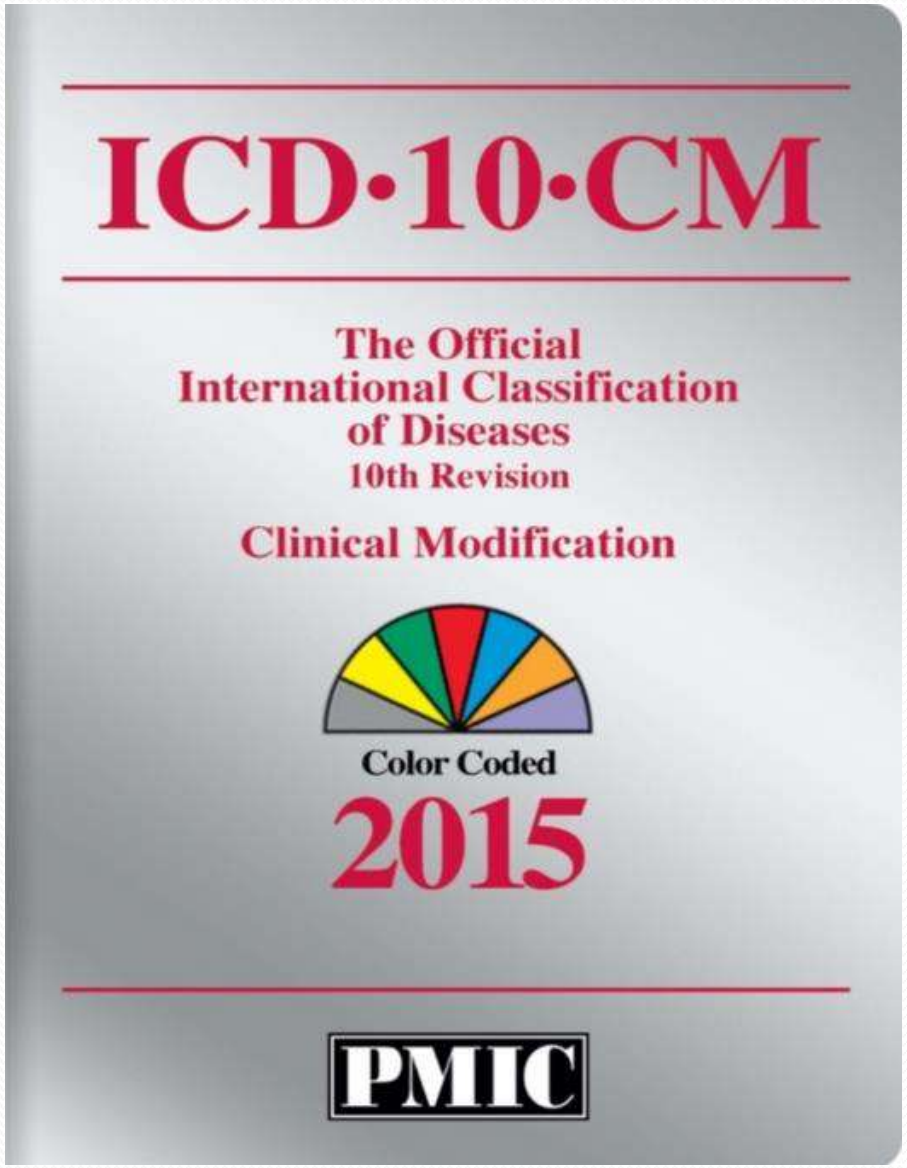
Dubon 2

- A utilization review (UR) decision is invalid and not subject to independent medical review (IMR) if it is untimely.
- Legal issues surrounding timeliness of a UR decision must be resolved by the Workers' Compensation Appeals Board (WCAB), and is precluded from the IMR process.
- Other treatment disputes regarding a UR decision must be settled through the IMR process.

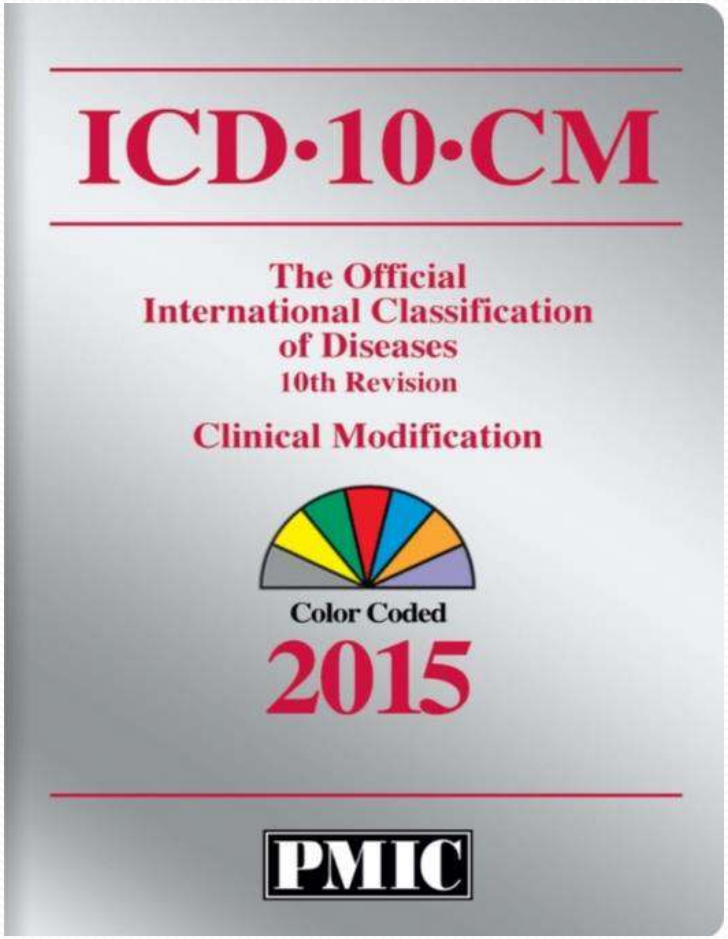
Algorithm for Chiropractic

- The following algorithm will help the requesting provider determine if their patient meets the criteria defined in the medical treatment guidelines.
- The doctor must be sure to include the details in the guidelines to justify to UR that the treatment is in fact medically necessary.
- UR is only looking for medical necessity and the decision must be based on the treatment guidelines.
- Doctors who do not follow the treatment guidelines will most likely never have their treatment requests approved in UR.


Chiropractic
Subjective or Objective Improvement within First 6 Visits?
No
Yes
Non-Certify
Chronic Pain Caused by Musculoskeletal Pain?
Radiculopathy?
Yes
No
No
Yes
1. Objective Measureable Gains
2. Functional Improvement
3. Increased ADL's
4. Progressive HEP
5. Subjective Improvements
Acute Phase: Has Manipulation Shown Improvement in 3-4 Weeks?
See "Chronic Pain Caused by Musculoskeletal Pain" Box
Yes
No
Non-Certify
Certify Chiropractic (Up to 6 visits)


ICD·10·CM
The Official
International Classification
of Diseases
10th Revision
Clinical Modification
Color Coded
2015
PMIC

- ICD-9 ~ 14,000 Codes
- ICD-10 ~ 70,000 Codes



ICD-10-CM

- 21 Chapters
- **Chiropractors will typically use ~5 chapters**

- Chapter 6: Diseases of the Nervous System (G00-G99)
- Chapter 13: Diseases of the Musculoskeletal System & Connective Tissue (M00-MM99)
- Chapter 18: Symptoms, Signs and Abnormal Clinical & Laboratory Findings Not Elsewhere Classified (R00-R99)
- Chapter 19: Injury, Poisoning & Certain Other Consequences of External Causes (S00-T88)
- Chapter 20: External Causes of Morbidity (V00-Y99)

Dummy Placeholder "x" is used for Future Coding Expansion

Letter	Number or Letter						
1ST Digit	2nd Digit	3rd Digit		4th Digit	5th Digit	6th Digit	7th Digit
S	3	2	.	0	1	0	A
Category				Etiology, anatomic site, severity			Added code extensions for obstetrics, injuries and external causes of injury

Length: 3-7 digits
First character: Letter only (all letters except U are used)
Character 2: Number only
Characters 3-7: Numbers or letter
Decimal: After 3rd character
Placeholder: Use of "x" as a dummy placeholder
Letter format: Letters are case-sensitive

Color Coding

Three digit code that requires the addition of 4^{th} – 7^{th} digits. Coding to higher level of specificity is required.

Three digit code that may be reported without additional digits.

Unspecified code. Descriptions include the term "unspecified." Use only if a more specific diagnosis is not known or available.

Nonspecific code. Descriptions include the term "nonspecific, unspecified, other specified or other." A report *may* be required by insurance carriers.

Manifestation codes. Used only to code the manifestation of an underlying disease. Code the underlying disease first.

Document

- Good documentation allows tracking of care rendered
- Document which treatment services were successful (which were not)
- Records MUST be **legible**
- Include presenting problems & examinations
- Include **Plan & Goals**
- Use **SOAP** format
- Include **Clinical Rationale** leading to your diagnosis

Alphabetical vs. Tabular ICD-10 List

- **Alphabetical List:**
- Use the alphabetical list to locate possible range of conditions to match your diagnosis
- There is not a 1:1 match between ICD-9:ICD-10
- Start with alphabetical list, but will need to code to highest specificity (i.e. laterality)

- **Tabular List:**
- Contains the ICD-10 codes to use based on your diagnosis
- Note Excludes 1 & Excludes 2

ICD-10-CM

- **Example:**
- Cervical Disc Disorders - Radiculopathy
- ICD-9: **723.4**
- ICD-10: **M50.0** Cervical Disc Disorder with Radiculopathy (Not Billable – Must specify 5th digit)
- ICD-10: **M50.10** Unspecified Cervical Region
- ICD-10: **M50.11** High Cervical Region
- ICD-10: **M50.12** Mid-Cervical Region
- ICD-10: **M50.13** Cervicothoracic Region

ICD-9 to ICD-10 Crosswalk Radiculopathy

Cervical Radiculopathy	723.40	M54.12
Thoracic Radiculopathy	724.4	M54.14
Lumbar Radiculolapthy	724.4	M54.16
Lumbosacral Radiculopathy	724.4	M54.17

ICD-10-CM

Transition from ICD-9 E Codes to ICD-10

MVA - Driver (A = Initial Encounter)	E812.0	V49.88XA
MVA - Passenger (A = Initial Encounter)	E812.1	V49.59XA
MVA - Injuring Motorcyclist (A = Initial Encounter)	E812.2	V29.49XA
MVA - Injuring Pedal Cyclist (A = Initial Encounter)	E812.6	V13.9XXA
MVA - Injuring Pedestrian (A = Initial Encounter)	E812.7	V03.10XA

ICD-9 to ICD-10
Elbow Diagnoses

Elbow Pain - unspecified	719.43	**M25.529**
Elbow Pain (Right)	719.43	M25.521
Elbow Pain (Left)	719.43	M25.522
Elbow - Lateral Epicondylitis, unspecified elbow	726.32	M77.10
Elbow - Medial Epicondylitis, unspecified elbow	726.31	M77.00

ICD-9 to ICD-10
Knee Diagnoses

Knee - Pain (Unspecified)	**719.46**	**M25.569**
Knee - Pain (Right)	719.46	M25.561
Knee - Pain (Left)	719.46	M25.562
Knee - ACL Sprain (Unspecified)	**844.2**	**S83.519A**
Knee - ACL Sprain (Right) Initial Encounter	844.2	S83.511A
Knee - ACL Sprain (Left) Initial Encounter	844.2	S83.512A
Knee - ACL Sprain (Right) Sequela	905.7	S83.511S
Knee - ACL Sprain (Left) Sequela	905.7	S83.512S
Knee - MCL Sprain (Unspecified)	**844.1**	**S83.419A**
Knee - MCL Sprain (Right) Initial Encounter	844.1	S83.411A
Knee - MCL Sprain (Left) Initial Encounter	844.1	S83.412A
Knee - MCL Sprain (Right) Sequela	905.7	S83.411S
Knee - MCL Sprain (Left) Sequela	905.7	S83.412S
Knee - Meniscus Tear (Unspecified)	**836.2**	**S83.209A**
Knee - Meniscus Tear (Right) Initial Encounter	836.2	S83.206A
Knee - Meniscus Tear (Left) Initial Encounter	836.2	S83.207A
Knee - Meniscus Tear (Right) Sequela	905.7	S83.206S
Knee - Meniscus Tear (Left) Sequela	905.7	S83.207S

Sprain vs. Strain
S13 vs. S16

- **S13 Codes (Sprain)**
- Dislocation and Sprain of joints & ligaments @ Neck
- Includes:
- Avulsion, Laceration, Sprain, Traumatic Tear
- **Excludes2**: Strain of muscle or tendon @ Neck

- **S16 Codes (Strain)**
- Injury of muscle, fascia, tendon @ Neck
- **Excludes2**: Sprain of joint or ligament @ Neck

ICD-9 to ICD-10 Crosswalk

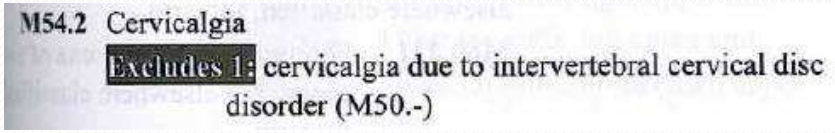
Diagnosis	ICD-9	ICD-10
Cervicalgia	723.1	M54.2
Thoracic Myofascial Pain	724.1	M54.6
Lumbago	724.2	M54.5
Cervical Sprain of ligaments, initial encounter	847.0	S13.4XXA
Cervical Sprain of joints and ligaments of other parts, initial encounter	847.0	S13.8XXA
Cervical Strain (A = Initial Encounter)	847.0	S16.1XXA
Cervical Strain (D = Subsequent Encounter)	847.0	S16.1XXD
Cervical Strain (S = Sequela)	847.0	S16.1XXS
Thoracic Sprain of ligaments, initial encounter	847.1	S23.3XXA
Thoracic Sprain of other specified parts, initial encounter	847.1	S23.8XXA
Lumbar Sprain of ligaments, initial encounter	847.2	S33.5XXA
Lumbar Strain (A = Initial Encounter)	847.2	S39.012A
Lumbar Strain (D = Subsequent Encounter)	847.2	S39.012D
Lumbar Strain (S = Sequela)	847.2	S39.012S

Exclude Notes

- **Excludes 1**
- A type 1 Excludes note means "NOT CODED HERE!"
- Excludes 1 indicates that the code excluded should never be used at the same time as the code above the Excludes 1 note.
- Excludes 1 is used when 2 conditions cannot occur at the same time (i.e. Congenital vs. Acquired)

Exclude Notes

- **Example: Excludes 1**



Do not code M54.2 with any other M50.- codes

M50.- codes include cervicalgia

OTHER DORSOPATHIES (M50-M54)

Excludes 1: current injury – see injury of spine by body region
discitis NOS (M46.4-)

M50 Cervical disc disorders
Note: code to the most superior level of disorder
Includes: cervicothoracic disc disorders with cervicalgia
cervicothoracic disc disorders

M50.0 Cervical disc disorder with myelopathy
M50.00 Cervical disc disorder with myelopathy, unspecified cervical region
M50.01 Cervical disc disorder with myelopathy, high cervical region
M50.02 Cervical disc disorder with myelopathy, mid-cervical region
M50.03 Cervical disc disorder with myelopathy, cervicothoracic region

M50.1 Cervical disc disorder with radiculopathy
Excludes 2: brachial radiculitis NOS (M54.13)
M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region
M50.11 Cervical disc disorder with radiculopathy, high cervical region
M50.12 Cervical disc disorder with radiculopathy, mid-cervical region
M50.13 Cervical disc disorder with radiculopathy, cervicothoracic region

M50.2 Other cervical disc displacement
M50.20 Other cervical disc displacement, unspecified cervical region
M50.21 Other cervical disc displacement, high cervical region
M50.22 Other cervical disc displacement, mid-cervical region
M50.23 Other cervical disc displacement, cervicothoracic region

Exclude Notes

- **Excludes 2**
- A type 2 Excludes note represents "NOT INCLUDED HERE"
- Excludes 2 note indicates the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time.
- When Excludes 2 note appears under a code, it is acceptable to use both the code and the excluded code together.

Exclude Notes

- **Example: Excludes 2**

M50.1 Cervical disc disorder with radiculopathy

Excludes 2: brachial radiculitis NOS (M54.13)

M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region

M50.11 Cervical disc disorder with radiculopathy, high cervical region

M50.12 Cervical disc disorder with radiculopathy, mid-cervical region

M50.13 Cervical disc disorder with radiculopathy, cervicothoracic region

It is allowable to code M50.1 (Cervical disc disorder with radiculopathy) –AND- M54.13 (Brachial Radiculitis NOS)

Both conditions may be present at the same time and distinct.

NOTE: Code the cervical disc disorder by level of the cervical spine.

Verify Payer Guidelines

- Check payer guidelines to ensure which codes are allowable and reimbursable
- Check preemptively to avoid delays in receiving payment

Updated DWC Forms for ICD-10

- Doctor's First Report
- PR-2
- PR-3
- PR-4

DWC form RFA

- Always enter the frequency/quantity of treatments you are requesting.
- The amount you request is what will be reviewed for authorization, and what the provider will be held to when billing.
- The DWC form RFA must be attached to your actual Request for Authorization (RFA); DFR, PR-2 or Narrative RFA.
- The DWC form RFA alone is not sufficient to justify why your patient needs the care you have requested.

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☒ New Request ☐ Resubmission – Change in Material Facts

☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health

☐ Check box if request is a written confirmation of a prior oral request.

Employee Information			
Name (Last, First, Middle): LAST, First			
Date of Injury (MM/DD/YYYY): 03/07/2014		Date of Birth (MM/DD/YYYY): 06/20/1920	
Claim Number: 1234567890 EAMS#: ADJ-123456		Employer: City of San Jose	
Requesting Physician Information			
Name: Glenn Crafts, DC			
Practice Name: Chiropractic Pain Care Center		Contact Name: Glenn Crafts	
Address: 123 Rose Blvd., Suite 123		City: San Jose	State: CA
Zip Code: 95128	Phone: 408-555-1234	Fax Number: 408-555-1235	
Specialty: Chiropractic		NPI Number: 1234567890	
E-mail Address:			
Claims Administrator Information			
Company Name: Managed Care Administrators		Contact Name:	
Address: PO Box 123		City: Concord	State: CA
Zip Code: 94522	Phone: 925-555-1234	Fax Number: **925-555-1235**	
E-mail Address:			
Requested Treatment (see instructions for guidance; attached additional pages if necessary)			
List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.			

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Lumbosacral Radiculitis	724.4	Chiropractic Manipulation	98940	8 Treatments
Lumbosacral Radiculitis	724.4	Myofascial Therapy	97250	8 Treatments
Lumbosacral Radiculitis	724.4	Therapeutic Exercise	97110	8 Treatments
Lumbosacral Radiculitis	724.4	Interferential Therapy	97014	8 Treatments
Lumbosacral Radiculitis	724.4	Ultrasound	97035	8 Treatments
Lumbosacral Radiculitis	724.4	Traction	97012	8 Treatments

Requesting Physician Signature:	Date: **04/8/2015**

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

Justify what you bill for

- The PR-2 helps Bill Review (BR) determine if you have procedurally coded your treatment correctly.
- Bill Review will match which codes you bill against which codes were authorized or approved.
- The level of re-exam (if any) billed is also justified by how the provider documents their findings.

State of California Additional Pages Attached ☐
Division of Worker's Compensation

PRIMARY TREATING PHYSICIANS PROGRESS REPORT (PR-2)

Check the box (es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e. has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3 or IMC Form 81556.

☒ Periodic Report (required 45 days after last report) ☒ **Change in treatment plan** ☐ Discharged
☐ **Change in work status** ☐ Need for referral or consultation ☐ Info. Requested by: _____
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☒ other: **RFA (Prospective- 8 Visits)**

Patient:
Last: WORKER First: Joe M.I: Sex: M DOB: 06/20/29
Address: 1001 Street Drive City: San Jose State: CA Zip: 95123
Occupation: Operator SS#: 000-00-0000 Phone: 555-555-0000
Claims Administrator: 925-555-0000 Claims Examiner: Adjustor Jones Email: adjustor@adjustor.com
Name: **Claims Administrator** Claim Number: **123456789** **EAMS#: ADJ-12345** D.O.I.: 03/07/2014
Address: PO Box 000 City: San Jose: CA Zip: 94123 **UR Fax: 000-555-0000**
Employer name: City of ABC

Subjective complaints: (As of 04/06/15)

Patient has continued to show and demonstrate functional improvement with treatment to date. The outcome measures listed below clearly confirms that he has improved with diminishing Roland Morris scores, which began at 11/50 to now 5/50. He continues to work full duty without any restrictions. I kindly request that an additional 8 visits be authorized to continue to gain function, increase range of motion, decrease pain, and fully restore ADLs to this injured worker and most importantly to prevent losing any gains to date with regard to the aforementioned and including strength, limited neurological deficits/paresthesias into his lower extremity and ability to perform his work duties. The goal is to continue to achieve positive symptomatic and objective measureable gains in functional improvement to return to pre-injury level. He previously reported moderate lower back pain that may become severe and refers into the right lower extremity, which is now reported as slight pain becoming moderate pain at its worst. Frequency of pain is also decreased with care from frequent to constant, which is now intermittent. Difficulty to perform ADLs has also improved (i.e. able to drive/ride motorcycle longer without back/leg pain, improved lifting, pushing, pulling ability with diminished LBP).

Objective findings: (As of 04/08/15)

Inspection: Right antalgic lean resolved.

Palpation: Palpable tenderness/trigger points with moderate (previously severe) spasm over lumbar paraspinals, right quadratus lumborum, and right piriformis. Right posterior serratus inferior trigger point resolved.

Lumbar AROM: Moderately (previously severely) diminished with flexion, extension; Slight (previously moderately) decreased with left (previously bilateral) lateral flexion and rotation.

Orthopedic Exam: (+) SLR on the right for localized SI joint pain & upper hamstrings. (prior pain into the right gluteus resolved). (+) Right Seated Kemps for SI joint pain locally (previously elicited radiation into the right gluteus.) Valsalva was unremarkable. Seated Dural Nerve Root Stretch test produced localized lumbar pain/restriction in forward flexion.

Myotomal Testing: (4-5/5) Lumbar pain with psoas resolved, but mild to slight pain with quadriceps and slight to moderate pain with hamstrings testing.

Neurological Testing: DTR's +2/4 B/L UE. Other neuro tests unremarkable (light touch, 2 pt discrimination, vibration)

Outcome Measure Tools: Roland Morris

03/23/15=RM: **11**/50
04/06/15=RM: **5**/50

Diagnoses:

1. LUMBAR SPINE UNSPEC. RADICULITIS (724.4)

Treatment Plan: Chiropractic Manipulative Therapy with Ice/Heat (98940), Myofascial therapy (97250), Therapeutic exercises (97110), Interferential therapy (97014), Traction (97012) and Ultrasound (97035); 2 *times a week for 4 weeks = 8 Chiropractic Visits*

UR REQUEST FOR PRE-AUTHORIZATION (PROSPECTIVE): 8 TREATMENTS

Home care exercises: Static hamstrings, quadratus lumborum & piriformis stretching and core stabilization exercises as described at this office.

Work/Status: This patient has been instructed to:

- ☐ Remain off work until: _____
- ☐ Return to *modified* work on _____ with the following limitations or restrictions:
- ☑ Return to full duty on 04/06/2015 with no limitations or restrictions

Primary Treating Physician: Date of exam: 04/06/15

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3

Signature: _____ Cal. Lic. # DC-12345

Executed at: Santa Clara County, CA Date: 04/08/15
Name: Glenn Crafts, D.C., Q.M.E. Specialty: Chiropractic
Address: 123 N. Rose Blvd., Suite 101 San Jose, Ca 95123 Phone: (408) 555-1234
Next report due no later than: 05/23/2015 Fax: (408) 555-1235

DWC Form Pr-2 (rev. 1/1/99)

Bill What Was Authorized by UR

- Make sure your treatment dates match the authorization date range from the UR certification letter.
- Make sure you bill only for the number of visits authorized.
- Make sure to include the RFA (DFR, PR-2, Narrative RFA) that was authorized for the visits being billed to substantiate level of care rendered.

Claimant: [redacted]

Claim #: [redacted]
DOI: 03/07/2014
RFA Received: 04/08/2015
Decision Date: 04/17/2015

Employer: [redacted]

Carrier/TPA:
Claims Examiner:
Review #:

UTILIZATION REVIEW DETERMINATION

[redacted] *Managed Care has been asked to notify you that the adjuster,* [redacted] *has given authorization* for the below noted treatment request.

REQUEST FOR AUTHORIZATION:

Additional chiropractic visits for low back Qty. 8

After careful review of the submitted medical information listed below, the determination is noted below.

DETERMINATION:

Your Initial Prospective UR request has received a recommendation of: Carrier Approval.

Authorization Timeframe:
04/17/2015 - 07/17/2015

Should this employer be part of a specific network, facility and/or vendor information is noted below.

Proof of Service

How can you prove you sent your treatment request?

- Proof of Service
- Email confirmation
- Fax proof/confirmation of delivery

Don’t forget to bill for your PR-2 & Re-Exam

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 7244 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL RE

23. PRIOR AUTHORIZATION NUMBER

	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.
1	05	06	15	05	06	15	11		WC002		A	15 00	1		NPI
2	05	06	15	05	06	15	11		99213	25	A	47 60	1		NPI

Don't forget to bill for your PR-2 & Re-Exam

OMFS:

WC002 = $12.01
99213 = $89.81

Voucher	DOS	Procedure/ Modifier	Units	Billed Charges	FS/UCR Reduction	Contract Reduction	Amount Paid	Reason Code
M39776710	04/08/2015	WC002	1	15.00	2.99	2.40	9.61	AN041-R, AN042-R
M39776711	04/08/2015	99213	1	47.60	0.00	9.52	38.08	AN041-R, AN042-R

Reason Codes

AN041-R Discount agreed to in Preferred Provider contract with: Align Networks Inc

AN042-R Charges exceed state fee schedule or maximum allowable amount

Up to 1 Hour ~ Physical Medicine Modalities

- Enter separate line items for the same modality performed on the same DOS
- Example: 4 units of 15 minute increments of physiotherapy to account for 1 hour of care
- NOTE: Cascading applies to each line item
- 100%, 75%, 50% 25%

Resources

- State of California Dept. of Insurance – *www.insurance.ca.gov*
- UR and Causation section of FAQs: *http://www.dir.ca.gov/dwc/UtilizationReview/UR_FAQ.htm*
- Division of Workers' Compensation Dept. of Industrial Relations - *http://www.dir.ca.gov/DWC*
- URAC – *www.urac.org*
- MTUS Regulations: *http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS_Regulations/MTUS_Regulations.htm*.
- ACOEM-Occupational Medicine Practice Guidelines 2nd Edition 2004
- CWCI
- ICD-10 CM PMIC 2015

Thanks for taking CE Seminars with Back To Chiropractic.
I hope you enjoyed the course. Please feel free to provide feedback.

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Services & Listings People helping people for free

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