MASSAGE THERAPY
ISSUES IN INSURANCE REIMBURSEMENT
(8 CE Hours)

Learning objectives

- Distinguish between coverage associated with private health insurance, personal injury insurance, and workers’ compensation coverage.
- Explain how personal injury and motor vehicle accidents are more receptive to insurance reimbursement than other types of coverage.
- Name the primary standardized billing form for insurance reimbursement.
- Explain the role of Workers’ Compensation in cases of on-the-job injury.
- List the four main steps of SOAP charting and identify the information associated with each part.
- Explain what ICD and CTP codes are, and where and how they are used.
- Define “functional outcomes” and their significance in SOAP charting.
- Define “scope of practice” and its relationship to insurance reimbursement for massage.

Introduction

Many would say that reimbursement for massage therapy through a client’s insurance coverage is a mixed blessing, at best. While inclusion in insurance programs can mean a steady source of income, it is associated with a daunting collection of forms and information; a substantial amount of documentation of a specific nature that you will need to understand and fill out accurately. This is a complicated and time-consuming process, and payment is never completely guaranteed. However, many massage therapists find insurance reimbursement an excellent business opportunity, once they figure out the process.

The potential advantages and disadvantages of working with the insurance industry will not be discussed at length in this chapter. However, a number of authors have written useful guides for industry professionals that provide more commentary on these issues. To read about this topic in greater detail, see the sources listed below:

For definitions related to insurance reimbursement, see: http://www.florida-health-insurance.com/defin.html

Many free useful forms for your massage therapy business that are discussed in this chapter are available at: http://www.sohnen-moe.com/forms.php

Diana Thompson’s “Hands Heal; Communication, Documentation, and Insurance Billing for Manual Therapists,” is the standard in the industry.

Also see:

The Massage Insurance Billing Manual, Julie Onofrio at www.bodyworker.org

Medical Massage Office Insurance Billing, David Luther and Marjorie Callahan

Both the American Massage Therapy Journal (www.amtamassage.org/journal) and Massage Magazine (www.massagemag.com) have a number of informative articles discussing the subject of insurance reimbursement for massage therapy.

The complex nature of insurance reimbursement raises many questions and issues regarding the practice and business of massage therapy and its status as a healthcare service. Be aware that insurance regulations vary by state, type of plan, and type of healthcare. This chapter will provide important, basic information regarding policies, codes, and procedures, but even this information may not be current by the time you review this material.

Remember, always, that your particular scope of practice, state, and, possibly, your region of the state, may be governed by specific guidelines of which you need to be aware. Because of these professional and regional differences, as well as the current state of flux regarding the status of massage therapy in mainstream healthcare, you will need to adjust your practices and procedures accordingly. Changes occur every year.

In some cases, massage therapists discount their prices or sign restrictive covenants in exchange for reimbursement. These are individual choices each practitioner must make for him or herself. Insurance billing can be time-consuming, costly, and difficult. You will likely spend more time on the phone, writing notes, and e-mailing to follow up your claims. All communication with doctors and insurance agents must be clear and well documented. On the other hand, once you have incorporated certain practices related to documentation and follow-up into your practice, you will find there is some order to the system.

A changing field

Insurance does not pay for relaxation or preventive therapeutic massage. It is reimbursable only as a treatment for rehabilitative purposes. Insurance companies navigating the poorly defined boundaries between “wellness massage” and what is coming to be known as “medical massage,” do not have well forged ways to determine who is or is not qualified to provide these services.

The AMTA requested, in December 2004, specific CPT (Current Procedural Technique) codes be developed and approved by the American Medical Association, for the evaluation and assessment of massage by massage therapists. This way, massage therapists will have specific codes to correctly bill for those procedures. This will help insurance companies recognize the legitimate reimbursement claims of massage therapists. Evaluation and reevaluation codes currently exist for the fields of physical therapy, occupational therapy, and athletic training.

According to the American Medical Massage Association (AMMA), Medical Massage is:

“A system of manually applied techniques designed to reduce pain, establish normal tissue tension, create a positive tissue environment and to normalize the movement of the musculoskeletal system. Medical Massage is a scientifically based method of manual therapy that seeks a clear understanding of the scientific principles of physiology that affect connective and soft tissue healing and treatment.”

This definition distinguishes between therapeutic massage as a preventive therapy and medical massage, a treatment specifically directed to resolve conditions diagnosed by a physician.

Medical Massage organizations like the USMMA (formerly the AMMA) have developed a program for a nationally certified Medical Massage Therapy, with an exam offered by list of approved providers. Medical massage typically utilizes physical therapy codes.

Many massage practitioners feel well within their scope of practice providing massage treatment without this extra training or additional certification, a situation that has created some conflict and tension within the field. Even individuals with this additional training, however, will likely find a brief education in the insurance system and understanding of common policies is important, ensuring practitioners know if and when they will be reimbursed. This chapter will furnish some of the information that can facilitate your management of a complicated system.
This chapter will help you determine:

- What services are within your legal scope of practice
- How to bill for your services which types of insurance will reimburse for manual therapy in your state
- What modalities are covered and what CPT codes correspond with them
- How to verify treatment and show improvement using functional outcomes

Types of medical coverage

A brief introduction to different types of medical coverage follows. A plan may be a part of private health insurance, personal injury insurance, or workers’ compensation coverage. You will find different types of insurance vary in the degree to which they accommodate insurance reimbursement for massage therapy. Motor vehicle and job injuries, for example, as well as managed care in certain states, have historically been more receptive to reimbursement for massage treatments. This will be discussed in more detail later.

Insurance coverage takes many forms, differing in countless variables, including, for example, the manner in which the insured chooses a physician or hospital, the amount and types of injuries covered, and details regarding fees and co-payments, etc. Large companies, like Blue Cross and Blue Shield, for example, offer a variety of different plans and products, including, for example, indemnity, major medical, managed care, and self-insurance programs, among others options. In dealing with insurance reimbursement, you will need to be able to identify exactly the type of coverage your client has.

Private health insurance

Private health insurance is, perhaps, the most inflexible or resistant regarding policies for reimbursement to massage professionals. In some cases, insurance will cover manual therapy only if the treatment is provided by a specific type of caregiver, for example, a physical therapist, or nurse. Some states are much more progressive in their policies. For example, the State of Washington has implemented legislative action to include a range of categories of health providers under specific provisions. Industry professionals anticipate a great deal of change in the next decade regarding the status of massage therapy as a standard medical modality included in health plan coverage.

Major medical and indemnity

Major medical and indemnity insurance policies are the more traditional healthcare policies that existed before managed care options were available. They typically refer to a health insurance plan with a high maximum benefit, and with comprehensive rather than scheduled benefits. Major medical insurance and indemnity insurance are typically only purchased by a small percentage of the population.

Major medical and indemnity (also called fee-for-service) are kinds of coverage that allow the insured individual to use any provider he/she chooses, with no restrictions regarding physicians or hospitals. Major Medical insurance typically covers the expense of major illness or injury, with relatively high maximum benefits and deductibles. The carrier pays for any medically necessary services specified in the policy to any type of provider.

Unlike PPO or HMO plans, there is no list or network for healthcare personnel. The only restrictions relate to provider licensing and treatments not excluded from coverage. Typically, the insurance pays the provider directly, or in some cases, pays the insured first, and the insured pays the provider. Most indemnity plans cover a specific percentage of customary and reasonable expenses after a deductible. The insured is responsible for the balance.

In most states, major medical and indemnity insurance have pre-established limits for medical services to specific providers. In Florida and Washington, major medical and indemnity insurance companies may not limit their payment for medically necessary services to only physicians or physical therapists, and are required to pay for medical massage treatments. Only these two states require major medical and indemnity insurance to pay licensed massage therapists for medically necessary massage.

Major medical/indemnity plans that pay massage therapists will always require the injured to pay the deductible and a percentage of the medical bills. A deductible is the amount the injured party has to pay before insurance will pay any portion. A percentage is set proportion of the total charges insurance pays after the deductible has been paid by the insured. The massage therapist is typically responsible for collecting from the injured individuals any balance not paid by insurance. Once a deductible is paid for major medical and indemnity policies, the insurance pays from 75-90% of the bill, leaving the individual with the remaining amount.

Managed Care Organizations (MCO)

The majority of people belong to managed care organizations (MCO), which come in a variety of types, including HMO, PPO, EPO, and POS, among others. Managed care organizations are responsible for coverage outlined in the MCO’s Evidence of Coverage, a document stating that they will only pay contracted providers according to specific guidelines. Managed care sets limits on fees, what types of services are covered, and who supplies the services. In addition, managed care programs typically require a referring HCP (healthcare provider) to administer and coordinate care with other healthcare providers.

In most states, MCO will not pay for massage treatment, even if a physician advises or prescribes it, because the system is simply not set up to reimburse massage therapists, as they are currently defined. Florida and Washington have laws requiring MCO to include massage therapists as preferred providers for medically necessary massage when it is prescribed by an approved contracted provider. A number of professional organizations, such as the United States Medical Massage Association (USMMA), for example, are pursuing changes in the status of certain types of massage. See www.Usmedicalmassage.org for current information on the status of compliance for managed care organizations paying massage therapists.

Health Maintenance Organizations (HMO)

HMO are health delivery systems that offer comprehensive health coverage for hospital and physician services for a prepaid, fixed fee. HMO contract with or directly employ participating healthcare providers, including hospitals, physicians, and other health professionals, and HMO members choose from among those providers for all healthcare services. Injured individuals who are members of an HMO must use only HMO providers within their network. HMO’s are one of the most popular, and fastest growing forms of healthcare coverage in the country. There are many different types.

A Health Maintenance Organization (HMO) plan typically requires that the insured select a primary care physician (PCP) from within the HMO provider network. This person is responsible for meeting the insured’s healthcare needs, either by treating him/her directly, or by referring him/her to other providers (such as specialists). Some HMOs operate their own facilities, staffed with their own salaried doctors, while others contract with individual doctors and hospitals to be part of the HMO.

HMOs usually have no deductibles or plan limits. For each visit, the user pays a small fee or copayment. As long as the insured sees the PCP or has an authorized referral to another provider, the insured’s out-of-pocket cost is the relatively small copayment per visit. If the insured chooses to go to another provider without a referral, however, regardless of whether the providers are or are not in the HMO network, the insured will be required to pay the total cost of the provider’s bill. Exceptions, such as emergencies, may be covered by the plan. HMO’s require the insured use the HMO’s doctors and facilities, as medical services outside the system are not covered.
HMOs vary enormously in contractual relationships with providers, reimbursement methods, and the use of discounted or capped fees for treatment. Providers may be asked to accept discounted or lower-than-normal fees (affinity plan) for their services. You may be asked to “bundle” all services into one fee (global fee schedule), and provide sessions or a treatment schedule dictated by your client’s insurance coverage requirements, rather than what may be best for his/her health.

**PPO**

A PPO is a preferred provider organization; a group of providers who have joined together, negotiating their rates for treatment with various health plans. PPOs are similar to the traditional fee-for-service (indemnity) programs, except that they primarily contract with independent providers. They were initially developed to provide some flexibility within an increasingly rigid system, bridging the gap between traditional indemnity insurance and the sometimes very limited HMO.

There are several national PPO organizations, and many local or regional PPO. In some cases, regional or local PPOs provide better rates, and more extensive provider coverage, than national organizations. The PPO provider that the insured plans utilizes is important, because ultimately, it dictates where the injured will get care, and how easy access to that care will be.

PPO selection is based not only upon cost, but also on provider access, and the quality of organizations that are part of the PPO. Some PPO plans require Primary Care Provider (PCP) referral and deductibles, and coinsurance, while other PPO plans offer co-pay benefits with no deductible for certain services. Unlike HMO, PPO utilize deductibles and plan limits, and may offer several different plans, ranging from the highest (full coverage) to the lowest (highest deductibles) cost.

A PPO plan encourages the insured to choose doctors, hospitals, and other providers that participate in the plan by increasing the portion of the bill they pay if the insured stays “in network.” The insured may choose to go “out-of-network” at any time, but if so, will have to pay a higher percentage of the provider’s bill. Services, other than the most basic medical office visits and emergency care, usually require pre-authorization by the PPO before any treatment commences. Many PPO require a primary care physician (PCP) take responsibility for coordinating the insured’s medical care. In many cases, each member of the network of doctors and hospitals agrees to accept a discounted fee for their services from the plan.

**EPO**

An Exclusive Provider Organization (EPO) plan is very similar to an HMO. With an EPO, the insured must select a primary care physician or physician “gatekeeper” who will be responsible for meeting the insured’s healthcare needs. In most EPO plans, as with an HMO, if the insured chooses to go out-of-network, he or she will have to pay 100% of the provider’s bills. Exclusive Provider Organizations (EPO) are similar to PPO, but only reimburse members for services rendered by providers in their network. A PPO may also make an EPO option available to payers.

In simple terms, an EPO is a much smaller PPO that offers a very limited number of providers, each of whom offer deeper discounts on their rates so they will see a higher volume of patients. This type of organization is becoming more popular, as it courses a middle road between an HMO and PPO. EPO can be set up in many different ways.

**POS**

POS stands for point of service plan. This is a variation of the HMO and EPO plans that is often described as an “open-ended HMO.” POS plans operate a lot like HMO, but allow the insured individual to choose a doctor or hospital each time he/she needs care. As with an HMO, the insured must pick a primary care physician within the network. Unlike an HMO, the insured may opt out of the network, but will usually have to pay a sizable deductible, with the plan paying 60-80% of the bill. The remainder of the bill must be paid by the individual out-of-pocket.

**IPA**

IPA, or Independent Practice Associations, are loosely organized networks of doctors who practice out of their own offices, treating either IPA or non-IPA patients. Usually, IPA coverage is available only to groups, with, in most cases, a small copayment for each visit. Under the IPA plan, some of the doctor’s income may depend on the plan’s success or efficiency. Participating doctors often share in any losses the plan sustains, or in any profits the plan makes.

**FMC**

Foundations for Medical Care (FMC) are physician organizations established by county or state medical societies. FMC operate similarly to IPA, in that they are composed of physicians practicing individually or in single specialty groups. FMC were the forerunners to IPA, providing physician and hospital services to specific employers. In the past few years, some FMC have also developed HMO, IPA and PPO options.

**Federal coverage**

Federal health insurance resources include the Health Care Financing Administration (HCFA), which is part of the U.S. Department of Health and Human Services, HCFA administers Medicare and Medicaid. No federal insurance programs, including Medicaid, Medicare, military programs like Champus and ChampVA, Federal Employees, or Group Trust pay massage therapists. Until uniform national standards are established and recognized by ERISA (the federal act governing federal employee insurance), each state will likely maintain its own licensing requirements.

**Personal injury**

Personal injury insurance claims are often related to automobile accidents (also known as MVA, motor vehicle accidents). In dealing with auto insurance carriers, you will need to be aware of the following types of coverage: Personal Injury Protection (PIP) and Medical Payments (MP or MedPay), secondary PIP or MedPay, third-party coverage (BI or Bodily Injury), and uninsured or underinsured motorist coverage (UM/ UIM).

Massage therapists may be able to bill personal injury insurance for medically necessary treatments in cases of negligence. If manual therapy is required, it may be covered under the at-fault party’s liability insurance. Treatments may be required until the client is returned to pre-injury status or reaches maximum medical improvement.

**Auto accidents**

Millions of people are injured each year in motor vehicle accidents. Most accidents are decided according to the law of negligence. An individual who negligently operates a vehicle may be required to pay any damages caused by their negligence, both to person and property. Drivers are required to exercise “reasonable care” according to the circumstances. Failure to use reasonable care is typically the basis for damages paid out in auto accident lawsuits.

Auto accident coverage forms a type of hierarchy: Typically, each individual involved in an auto accident relies first on his/her own policy’s medical benefits, regardless of who owns the auto involved in the accident. If the injured does not have his/her own medical benefits, coverage is pursued from the medical benefits of the owner of the auto in the accident. If there are no medical benefits (PIP/MedPay) covered, or they are already used up, the liability coverage (Bodily Injury or BI) of the negligent party is pursued. When a motorist is not negligent, and none of these resources are available or sufficient, the motorists own UM/UIM (uninsured or underinsured motorist) or the UM/UIM of the owner of the auto in the accident will pay. Additionally, if the auto accident occurred while the injured was working, his/her on-the-job injury insurance may be liable for paying medical expenses.

There are two main categories of auto insurance: first party and third party coverage. First-party coverage covers medical expenses for the insured individual, while third-party coverage is used to pay for injuries sustained to others, regardless of whose vehicle was involved in the accident.
accident. In general, third-party coverage refers to the liability coverage of the negligent or at-fault individual. Some insurance companies pay healthcare expenses directly when it is clear who was negligent. In many cases, however, healthcare providers have to wait until the case is settled at which time liability is determined. The time limit for this process varies in each state, but can be a period of years. It is useless to bill third party insurance until fault is determined.

No-fault insurance versus tort system
As a response to lengthy, costly court battles regarding fault in specific auto accidents, a number of states, including Florida, Colorado, Hawaii, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Dakota, Pennsylvania, and Utah, adopted no-fault insurance laws (sometimes referred to as personal injury protection or PIP). No-fault insurance requires medical healthcare benefits be included in auto insurance policies to cover medical expenses incurred both by individuals driving, riding as passengers, in the policy-holders car, and any pedestrian hit by the policy-holder’s car, regardless of fault.

There are two factors that give massage therapists a claim to third-party insurance reimbursement: the first is your status as an ancillary healthcare provider, defined by the qualifications outlined in your scope of practice, and the second is the specific terms of coverage in the relevant policy. Auto accident insurance law allow for ancillary providers to provide prescribed and medically necessary treatment in injury cases. Massage therapy is recognized as medically necessary for injury in motor vehicle accidents if you can verify treatments and show improvement.

Under a no-fault system, when you have an accident, your auto insurance provider automatically pays for your damages, regardless of fault, up to a specified limit. In exchange for this guaranteed payment, you must forego some of your rights to sue the other driver involved in the accident. By the same token, you are also protected from being sued in the event you are at fault in an accident. There are elements of no-fault in all auto insurance coverage.

Some states have switched from a no-fault system to tort. A tort is a civil wrong that is not a crime. Under tort auto insurance, someone has to be found at fault for causing a crash, and that person is responsible for payments. The no-fault system is intended to lower the cost of auto insurance by taking small claims out of the courts. Each insurance company compensates its own policyholders for the cost of minor injuries regardless of who was at fault in the accident. These “first-party” benefits, which are a mandatory coverage, vary by state with no-fault systems. In states with the most comprehensive benefits, a policyholder receives compensation for medical fees, lost wages, funeral costs and other out-of-pocket expenses.

The term “no-fault” can be confusing because it is often used to denote any auto insurance system in which each driver’s own insurance company pays for certain losses, regardless of fault. In its strict form, the term no-fault applies only to states where insurance companies pay “first-party” benefits and where there are restrictions on the right to sue. Drivers in no-fault states may sue for severe injuries if the case meets certain conditions. These conditions are known as the tort liability threshold, and may be expressed in verbal terms, such as death or significant disfigurement (verbal threshold), or in dollar amounts of medical bills (monetary threshold).

Typically, states require drivers to carry some minimum level of liability coverage, specified in both per-person and per-accident terms (for example, $10,000 per person/$20,000 per accident). Thus, the insurance company of the at-fault driver will compensate a third party for the losses sustained in an accident up to the policy limits. The at-fault driver’s own insurance covers his or her own injuries (for example, Medpay) and property damage (for example, collision), assuming he or she chooses to carry such insurance.

The table below summarizes differences in liability standards and insurance coverage by type of damage under typical no-fault and tort insurance systems.

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<th>Liability and Insurance Coverage Under No-Fault and Tort</th>
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<td>Optional Medpay or other first party health/disability insurance coverage</td>
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<tr>
<td>Third-Party</td>
<td>No liability below statutory PIP limits/Compulsory BI insurance for damages above PIP limits</td>
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PIP/Med Pay
The medical benefits portion of the auto insurance plan in no-fault states is known as personal injury protection (PIP or Med Pay). Personal injury insurance covers bodily and property damage and may be related to auto insurance (motor vehicle coverage is common), a homeowner’s policy, or commercial building insurance. Motor vehicle and personal injury coverage may allow payments for medically necessary services as long as the insured can verify treatment and show improvement.

Personal injury protection (PIP) provides coverage for medical and other expenses resulting from certain types of accidents, for people specified in the policy, regardless of who is at fault in the accident. In some recent cases, some insurance companies have redefined PIP coverage as limited to the policyholder’s family members only. In some states, like Washington and Florida, PIP is required, but a person can elect not to purchase PIP if they can prove they have other health insurance coverage and sign a waiver rejecting PIP. PIP policies usually have a time limit for which services can be billed that varies in each state. When it comes time to settle the case, insurance companies and lawyers will scrutinize healthcare services.

PIP covers, within specific limits, the medical and hospital expenses of the insured, others in the insured’s vehicles, and pedestrians struck by the insured. It will cover the insured’s own injuries on a first-party basis, without regard to fault. This is only available in certain states. PIP is relatively open to reimbursement for massage therapy in that you do not have to wait for fault to be determined. You are required to prove that care is reasonable and necessary treatment for injuries and that a referring healthcare provider prescribed the treatment as medically necessary.

Many levels of PIP coverage are available for purchase, with each state determining its own provisions for the amount of PIP coverage that must be purchased and the standard length of time this coverage is provided. No-fault insurance is the bare minimum as far as insurance benefits are concerned. Full coverage requires further types of essential coverage, including bodily injury, uninsured motorist, and collision. In some states PIP must be purchased, by law; in other states, it is optional. PIP is often mandated by states that have “no fault” laws.

Florida and Washington are the only two states in which massage therapists are included as contracted providers under this plan. In other states, it may be possible to get payment through an organization in your area, but it is much easier in Florida and Washington. Even in Florida and Washington, however, massage therapists do not always get paid simply because this is the law.
Medical Payments (MedPay) covers medical expenses to the injured insured in case of an accident and his/her injured passengers. It also covers pedestrians injured by a vehicle. Coverage is not based on fault, but is limited to the specific terms of the policy. MedPay is typically purchased with auto insurance coverage. The amount required varies by state.

States without no-fault laws are under a tort law system. Insurers in tort states may offer Med-Pay as optional insurance. Customers who choose not to purchase medical benefits must by law sign a waiver to show they are opting out of purchasing medical benefits and are aware of their potential liability in an accident. Because med-pay premiums are relatively inexpensive, the vast majority of policyholders typically pay med-pay coverage. Both PIP and Med-Pay make regular payments while the injured individual is under medical care.

If there is no PIP coverage, Med Pay may cover massage services, but Med Pay generally covers a lower dollar amount than PIP, and covers only medical expenses. Neither PIP nor Med Pay are affected by the determination of who was at fault in the accident. In some cases, injuries sustained by your client in an accident may be covered by one or more PIP or Med Pay policies.

For example, if Joe, a passenger in Tom’s car, is injured in an accident, Tom’s insurance will pay for medical expenses as the primary insurer, even though Joe has car insurance. Once Tom’s insurance is used up, Joe’s PIP insurance coverage can be used as a secondary PIP insurer if additional medical services are required. If Joe does not have PIP or Med Pay and Tom’s PIP is used up, Tom’s health insurance becomes the secondary insurer.

Bodily injury (BI) liability coverage

The majority of states require drivers to carry bodily injury (BI) insurance (also called third-party coverage), a type of liability insurance that covers the liability of the negligent or at-fault party for injuries sustained in an auto accident, covering the insured against claims for damages made by third parties up to some specified limit. The injured party typically seeks the negligent party’s BI coverage to pay a settlement when there is no coverage for medical benefits, or the coverage is not enough to cover needed services or care. Insurance companies may also go after BI coverage to recover PIP or Med-Pay expenditures paid by the not-at-fault insured’s policy.

BI, unlike PIP and Med-Pay, which are typically paid as expenditures are accrued, is sometimes paid out in a lump-sum settlement payment after the injured individual has reached maximum medical improvement (MMI) or the medical benefits coverage is used up and all medical bills have been submitted to the injured individual’s lawyer. In some cases, a settlement will also include additional money for pain and suffering, permanent impairment, future medical needs, and/or lost wages. BI settlement includes deductible and copayment fees.

Some states require BI insurance only; others require PIP; others require both, and some states require neither type of insurance. If the negligent party is insured, it is likely that BI will be available. Healthcare providers who wait for a BI settlement should know about a Letter of Protection Lien; a document signed by the injured individual and the attorney, designating the injured party as a creditor against the forthcoming settlement.

There are two types of third-party liability policies: bodily injury and property damage. Bodily injury liability pays other people for damages the policy owner has done to them, such as medical expenses, lost wages, and pain and suffering; property damage pays other people for damages done to their property. If someone files suit against the policy owner as a result of a car accident, these policies will provide monetary protection up to the limit of the policy.

Liability refers to the amount the insurance company is “liable” for in cases where the individual caused an accident. It is shown on the “Declarations” page of a policy. This coverage is typically shown with a slash ("/"") separating two numbers, such as: 25/50, or 100/300, where the first number is the dollar amount (in thousands) of total coverage in the event that one person is injured or killed, and the second number is the total dollar amount (in thousands) for an entire accident. This coverage also handles legal expenses involved in settling lawsuits.

Uninsured and underinsured motorist (UM/UIM)

In cases where neither medical benefits or BI are available, the injured individual may seek benefits based on Uninsured/underinsured motorist benefits. UM/UIM coverage is described by the same notation as bodily injury coverage (e.g., 100/300):

Uninsured, or “UM” coverage: An automobile coverage allowing for recovery when one is injured due to the negligence of another, when that at fault party does not have liability insurance coverage (BI).

Underinsured, or “UIM” coverage: An automobile insurance coverage where one may make a claim to recover damages in excess of the policy limits of the negligent party.

UM/UIM coverage pays the policy owner and his or her passengers for pain and suffering, lost wages, etc. in the event that the driver at fault can not be found (as in a hit-and-run), has no insurance, or has too little insurance to cover the damages. It is unlikely that the driver at fault will have enough coverage to pay the damages resulting from a serious accident. Further, while other policies can combine to offer the same kind of coverage as UM/UIM, there are several advantages to this type of coverage: UM/UIM is more comprehensive than most health or disability plans; it can cover loss of limb, pain and suffering, funeral expenses, etc; it has much higher coverage than other types of medical-expense car insurance, such as MedPay and PIP, and it is relatively inexpensive.

Many states require this UM/UIM coverage to protect an individual against a negligent person without liability insurance coverage or with minimal coverage that is not able to appropriately compensate an injured individual. In an accident with an uninsured negligent individual, a claim would be made on the insured’s own policy based on uninsured motorist coverage. The injured individual’s insurance carrier would pay any judgment rendered, up to the limits of the specific policy purchased by the insured.

If the person who caused the accident has liability insurance, but the policy limit of that liability insurance is less than the uninsured motorist coverage of the injured party, an additional claim may be made under the injured individual’s policy for underinsured motorist benefits, in case the injured individual’s damages exceed the limits of the other party’s liability coverage. Case law determines how these benefits are paid, with the maximum amount of recovery varying widely according to the facts of the case. Auto medical plans almost always have portions of medical bills that must be paid by the injured individual in the form of deductibles and a percentage of fees.

Workers compensation and job injury

Since 1948, all states have had some form of workers’ compensation in effect. Through this legislation, employers agreed to provide medical and indemnity (wage replacement) benefits to workers. The main objective of workers’ compensation is to provide necessary medical benefits and return the employee to work, quickly and safely, with little potential for re-injury. In recent years, workers’ compensation has become the primary remedy for the injured worker. It also protects employers from damage suits filed by the injured worker.

The Workers’ Compensation Division is responsible for the administration of the Workers’ Compensation Law, which ensures proper payment of benefits to employees injured on the job and encourages safety in the workplace. The main function of the Division is to ensure proper payment of compensation benefits along with necessary medical
To perform services as massage therapist your work may need to be carried out at a doctor’s office or be supervised by a doctor. Many labor boards post provider fee schedules and service manuals that guide billing procedures.

**How to become a preferred provider**

Washington and Florida are the only two states that widely accept massage therapists as contracted providers in the healthcare system. To have massage therapy services covered by an HMO or PPO, the massage provider will need to become a provider within that organization and follow its rules and regulations. The majority of states (excluding Washington and Florida) do not recognize massage therapists as healthcare providers. Recognition will likely become more common in more states as new legal decisions and precedents are set.

Contact your state insurance commissioner’s office or local health insurance companies to find out what is involved in becoming a provider. You may require a certain minimum amount of liability insurance or be in practice for a number of years to qualify. You are also typically subject to privacy regulations at your workplace and must have access for individuals with disabilities.

You will be asked to undergo an assessment or credentialing process with a review consisting of the following:
- A completed application.
- Professional references.
- Work history.
- Proof of educational history (including educational certificate, continuing education credits completed, etc.).
- Proof of licensure.
- Proof of liability insurance.
- Proof of registration/certification.
- Proof of professional affiliations.
- Signed contract agreeing to company policies and requirements for services (including “hold harmless” clause).
- Pass a background check for any complaints or disciplinary action.
- Review of client records.
- Inspection of work site.
- Accessibility of workplace.

Additionally, you may have to attend lessons, relating to aspects of billing or recordkeeping, for example, and participate in certain programs annually to maintain approval. You may be required to take SOAP charting classes or purchase liability insurance coverage. Some of these quality control programs require random auditing of treatments. Know that once you have signed a contract with the company, you are required to follow their rules, so read all contractual agreements carefully and have a lawyer review everything. Ascertain what requirements you must fulfill each year to maintain credentialing.

You should also be aware that the insurance company will determine which codes and services you are allowed to provide. In some cases, practitioners are required to take all injured individuals sent their way. If you can, it is useful, at this time, to learn what specific CPT codes you will be allowed to bill, and the fees associated with each type of code, and how many units of each type of code will be covered. In most cases, an injured individual is required to have a referral/prescription from a Primary Care Physician (PCP) who is responsible for diagnosing the condition. Massage services will only be covered in cases of injury or poor health for rehabilitative purposes, not for relaxation, stress-reduction, or wellness massage.

Insurance companies may deny payment for forms filled out incorrectly or lost. Learn what you must submit to the insurance company to secure payment, and realize you will probably be filling out more paperwork and following up with more phone calls. Insurance companies may also close their provider lists, allowing only a limited number of massage therapists to provide services for their network. Ask the same list of questions you asked the State Labor Board, previously listed in this chapter.

If you become a preferred care provider with an HMO or PPO, you should know that you probably will not be reimbursed for the full amount of your fees. Each insurance company determines what it will pay for massage therapy services. If you contract with the insurance company and your fee is higher than the specified amount allowed by insurance, you are not able to bill the difference to the injured individual you are treating. The managed care organization may also adjust the amount they pay at any time without notice, and may also require additional qualifications regarding payment. [Some massage therapists
feel insurance companies are continually making it harder to get paid and decreasing policy benefits for massage therapy treatments. For further information, see www.bodyworker.org, which provides a calculator to estimate the cost per client.

UCR

UCR refers to “usual, customary and reasonable fees” associated with a specific CPT code. These are amounts set by insurance companies for services and supplies that are medically necessary, recommended by a doctor, or required for treatment. Every insurance carrier has a payment rate for each test, procedure, and medical service. The rates are what the insurer has decided are appropriate for these services in the specific area. Health plans have different methods to determine what is usual and customary, but most insurance companies establish UCR fees according to the following criteria:

A “usual” fee is the fee that an individual provider most frequently charges for a specific procedure.

A “customary” fee is the fee level determined by the administrator of a benefit plan from actual fees submitted for a specific procedure. This fee establishes the maximum benefit payable for that procedure.

A “reasonable” fee is the fee charged by a provider for specific services or treatment that has been modified by complications or unusual circumstances. Therefore, it may differ from the provider’s usual fee or the benefit administrator’s customary fee.

The concept of using UCR fees to determine how much to reimburse patients covered by insurance for specific treatment was introduced by the insurance industry in the early 1960s. The Health Insurance Association of America (HIAA), an organization of 380 health insurance companies, surveys healthcare providers every year regarding their fees. The fee survey helps insurance companies set UCR fees. However, insurance companies are not legally required to use HIAA’s fee survey or anyone else’s information when setting UCR benefit levels. In fact, reimbursement calculations by insurance companies are unregulated and uncontrolled.

Unfortunately, UCR rates may be outdated and may not cover all costs. UCR fees are influenced by the fees providers charge in various geographic areas and by the population size. Geographic differences may not be fairly taken into account. For example, if a large city and a small town are considered to be within the same boundary, large discrepancies in fees may exist. UCR fees widely vary among carriers, and no two carriers use the same UCR definition. Additionally, carriers use different methods and time frames to determine UCR rates. Customary fee determinations made by carriers for the same procedure in the same city at the same time can vary enormously.

The process of billing through insurance companies is fraught with obstacles. Fee schedules with UCR may seem irregular or unreasonable. Even worse, individuals who contract with L&I and WC do not report the most positive results when requesting assistance. Procedures vary from policy to policy and insurance company to insurance company. You may be asked to charge lower fees for your services, or wait months or years for payments. You may find you have to pick and choose cases carefully; only taking them on when you feel with some certainty you will get paid. The more you learn, the better you will be at establishing boundaries and choosing with which clients to work.

Preverification of Insurance Coverage

This section will outline the process for patient preverification of insurance coverage, reviewing the information required and the forms or documentation associated with each step. In this process, you will find out what services or treatments are covered by the individual’s policy, the actual dollar amount of available benefits, whether you, as a massage therapist, qualify for payment, and the information necessary to fill out the claim form correctly.

This is the most important step in insurance reimbursement, and can potentially save you an enormous amount of wasted time and energy. For example, if you started treating a new patient without proper verification of insurance coverage, it might be weeks, if not months, before you learned that the patient’s insurance does not cover your services, benefits are already used up by other medical services, or the patient does not have the coverage he/she thought. By that time, you might have billed the individual hundreds of dollars that you will not get.

The first time you speak to a potential patient, use Form A: Patient Questionnaire. Find out the name of the physician and his/her area of specialty, who the attorney is, and the basic insurance information according to the guide.

In gathering information for the verification process, you will find a number of people particularly helpful in collecting accurate details. These individuals include:

- The prescribing physician’s billing secretary.
- The paralegal or secretary of the attorney, if an attorney is connected to the case.

You may also need to contact:

- The insurance company representative.
- The referring healthcare provider (HCP).
- The attorney.
- Human Resources personnel, in cases where insurance is provided through the individual’s work.

Many of these people have secretaries or assistants working with them who you will need to contact. Have all billing information and forms available when you make these calls, so you can quickly refer to any details you need, and take careful notes. It is useful to record the date as well as the name and title of the individual with whom you spoke, as well as what was said. If you are calling the referring HCP, have the prescription available. The individuals listed will likely answer all verification and qualification questions noted on the forms, or be able to refer you to someone who can.

The first person you will need to speak to, however, in this process, is the patient. Use Form A: Patient Questionnaire to get some basic information from the patient over the phone, when he/she makes the appointment. You can usually find out the name of the doctor and attorney, as well as a limited amount of information regarding insurance, from the patient, then turn to the insurance company, the doctor’s billing secretary and/or paralegal (among others) to fill out further information.

Form A: Patient Questionnaire

Patient Name ____________________________

Patient Social Security Number ____________________________

Insurance: [ ] Auto [ ] Workers’ Compensation (WC/L&I) [ ] Major Medical/Indemnity

Date of Injury/Illness: ____________________________

If Workers’ Compensation, name and telephone number of the employer at the time of injury:

Name ____________________________ Phone ____________________________

Insured’s Name, Social Security Number, and Insurance Company:

Name ____________________________ SS# ____________________________

Insurance Company ____________________________

[ ] Adjustor or [ ] Claim Representative’s name and phone number:

Name ____________________________ Phone ____________________________

Group or Policy number ____________________________

Claim or Case number ____________________________

Insurance Identification number: ____________________________

Referring physician’s name, address, and phone number:

Name ____________________________ Phone ____________________________

Date of Injury/Illness: ____________________________
When verifying information with Workers’ Compensation or L&I:

Use form A to fill out the first section of Form B. Then fill out the rest of Form B to confirm/verify information with the insurance company. With each call you make, record the date, time, the name and title of the individual with whom you spoke, and take accurate notes on what is said.

**Preverification questions:**

*When verifying information with the auto insurance representative:*

Record date and time of verification call. Write all pertinent information on verification form:

Hello. This is [your name] from [office]. May I speak to [name of adjustor or claim representative given to you by patient]? I would like to verify coverage (Repeat until you reach the right person. If another contact name and phone number are provided, be sure to record new information.)

Hello, I would like to verify coverage. The patient’s name is [patient’s name]. The insured is [insured’s name if different from the patient]. The identification number is [use social security number or claim/case number]. The date of the accident was [date given to you by patient].

What is the effective date of the policy?
What is the percentage of coverage?
How much is the deductible?
How much of the deductible has been paid?
What is the maximum $ amount of benefits?
What $ amount of benefits have been exhausted?
Can you confirm what CPT codes the doctor ordered?
Can you confirm that this policy will pay a massage therapist to perform this service(s)?
Do you have any restrictions on the use of any of these CPT codes by a massage therapist?
I would like to verify the following case number: [case #]
To what name and address should I mail the claim forms?

*When verifying information with Workers’ Compensation or L&I:*

Record date and time of verification call. Write all pertinent information on verification form:

Hello. This is [your name] from [office]. May I speak to [name of adjustor or claim representative given to you by patient]? I would like to verify coverage (Repeat until you reach the right person. If another contact name and phone number are provided, be sure to record new information.)

Hello, I would like to verify coverage. The patient’s name is [patient’s name]. The employer is [employer’s name]. The identification number is [use employer’s policy number]. The date of the accident was [date given to you by patient].

What is the effective date of the policy?
What is the maximum $ amount of benefits?
How much of the deductible has been paid?
What is the percentage of coverage?
What kind of policy is this? (i.e. HMO, WC, POS, etc.)
What is the out-of-pocket limit?
What percentage will be paid after the out-of-pocket limit has been reached?
Are there any restrictions on the use of Physical Medicine Codes?
Can you confirm what CPT codes the doctor ordered?
Can you confirm that this policy will pay a massage therapist to perform this service(s)?
Do you have any restrictions on the use of any of these CPT codes by a massage therapist?
I would like to verify the following case number: [case #]
To what name and address should I mail the claim forms?

**Form B: Preverification of Insurance Coverage**

**Part I:**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time of Call:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Insurance Company Name:**

**Phone:**

Fax:

**Adjustor/Claim Rep Name:**

**Other contact name and title:**

**Patient’s Name and Social Security Number:**

Name __________________________

SS# __________________________

**Insured’s Name and Social Security Number:**

Name __________________________

SS# __________________________

If Workers’ Compensation, Employer Name and Phone Number:

Name __________________________

Phone __________________________

**Date of Injury/Illness:**

**Case or Group Number:**

**Claim Number:**

**Insurance Identification Number:**

**Part II:**

**Contact Person Name:**

**Title:**

**Effective Date of Policy:**

**Type of Insurance:**

(HMO, WC/L&I, PPO, AUTO, etc…)

---

To what name and address should I mail the claim forms?

**Preverification questions for major medical/indemnity:**

Record date and time of verification call. Write all pertinent information on verification form:

Hello. This is [your name] from [office]. May I speak to [name of adjustor or claim representative given to you by patient]? I would like to verify coverage (Repeat until you reach the right person. If another contact name and phone number are provided, be sure to record new information.)

Hello, I would like to verify coverage. The patient’s name is [patient’s name]. The insured is [insured’s name if different from the patient]. The identification number is [use social security number or claim/case number]. The date of the illness/injury/accident/loss was [date given to you by patient].

What kind of policy is this? (i.e. HMO, WC, POS, etc.)
What is the effective date of the policy?
What is the percentage of coverage?
How much is the deductible?
How much of the deductible has been paid?
What is the maximum $ amount of benefits?
What $ amount of benefits have been exhausted?
Can you confirm what CPT codes the doctor ordered?
Can you confirm that this policy will pay a massage therapist to perform this service(s)?
Do you have any restrictions on the use of any of these CPT codes by a massage therapist?
I would like to verify the following case number: [case #]
To what name and address should I mail the claim forms?
Percentage of Coverage: _______ (100%, 80%, Other…)

Requires a Copayment? □ Yes □ No Amount: $__________

Requires a Deductible? □ Yes □ No Amount: $__________

Deductible Paid? □ Yes □ No Amount: $__________ What date will the next deductible be due? ________________

Maximum amount of benefits? $__________ Amount exhausted? $__________

Out-of-pocket limit? %/$ paid after out-of-pocket reached? ________________

According to the law, patients will be billed for the following outstanding responsibilities:

Copayment $__________
Deductible $__________
Percent/$/Other___________________ Are there any limitations or restrictions on this patient’s policy? (Note below): ______________________

1. Is massage therapy a benefit covered by the patient’s policy? □ Yes □ No
2. Is the patient eligible for the massage therapy benefit? □ Yes □ No [Will need diagnosis and ICD-10 codes]
3. Am I eligible to provide the massage therapy services? □ Yes □ No [Provide professional license/certification information]
   ‣ If an answer above is “no,” bill the patient for manual therapy services
   ‣ If the answer to all three questions is “yes,” continue verification questions below

4. Which massage therapy services are authorized?
   Service 1: ___________________ CPT Code: ___________________
   Any restrictions/limitations (i.e., max units and reimbursement rate allowed)? ___________________
   Service 2: ___________________ CPT Code: ___________________
   Any restrictions/limitations (i.e., max units and reimbursement rate allowed)? ___________________
   Service 3: ___________________ CPT Code: ___________________
   Any restrictions/limitations (i.e., max units and reimbursement rate allowed)? ___________________
   Service 4: ___________________ CPT Code: ___________________
   Any restrictions/limitations (i.e., max units and reimbursement rate allowed)? ___________________
   (Add lines as necessary)
[Reconfirm] Will the insurance company pay massage therapists to provide services?
□ Yes □ No
If yes, number of visits allowed: ________________

If yes, number of visits used this year: ________________

Maximum total amount to be paid for this type of treatment: $__________

Mailing address for claim:
Attn: ___________________ Company: ___________________

Mailing Address: ___________________
City/State/Zip: ___________________

Have complete information before filing a claim. The great majority of delayed claims are associated with inaccurate or missing information. Each company and type of insurance has its own rules and regulations regarding reimbursement and billing, so you will need to confirm this information for each new patient and each new condition being treated.

Basic rules of documentation and recordkeeping
Proper documentation and recordkeeping is a critical, if mundane, dimension of a successful practice. Keep notes legible and accurate. If it is ever necessary to refer to files some time in the future (in a medical emergency or legal proceedings, for example), the context and details of your notes should be clear. Other healthcare personnel will need to know the background, presenting status, actions taken and the results, with some discussion of treatment strategies and expected objectives. Adhere to the following guidelines for preparing and maintaining records:

◦ Maintain accurate and truthful records: record only factual information, observations, and actions. Don’t record your opinions, or conjecture about the client or his/her condition.

When recording statements made by your client (regarding an injury, for example), use quotation marks to demarcate the client’s words. Keep a separate file for personal notes or any material of a speculative nature.

◦ Make sure the forms you use to collect client information are appropriate to your practice and cover all pertinent areas. Make sure forms are free of errors and are easy to read and understand.

Questions should be stated simply. Avoid jargon or complicated medical terminology, or define terms, as needed. Review forms on a regular basis, and revise or simplify confusing formatting or content.

◦ Take a comprehensive case history and review it with the client before beginning treatment. This should include an overview of the client’s general state of health and thorough medical history, his or her reason(s) for seeking massage therapy, onset and duration of problematic symptoms, medical history of family members (if applicable), and occupational background.

◦ Train staff members to record client histories and other important information properly and thoroughly, and to ask appropriate follow-up questions if there is any ambiguity in a response. Implement some structure or mechanism to ensure this information is complete for every client and answers are recorded in sufficient detail. Review any personal or medical information taken by other staff members in a personal interview with the client to ensure information was recorded properly and in adequate detail.

◦ Areas that do not apply to a specific client should be marked “N/A” (non applicable) rather than left blank.

Develop a short, simple form that clients can use to note their progress (or lack of progress) at each visit.

◦ Document any client non-compliance with the care plan, including canceled appointments (dnka = did not keep appointment), refusal or failure to follow healthcare instructions and/or take needed medication, activity or behavior that poses a risk to the client’s health. Communicate the rationale for your opinion and do not proceed with any action that runs counter to your professional judgment.

◦ If you feel the client’s disregard for professional recommendations is putting him or her at risk, have the client sign a form acknowledging that he or she has been informed of the potential consequences of their action or inaction, and is choosing to refuse recommended treatment.

◦ Notes should be legible as well as accurate. Pay attention to your handwriting and use clearly written and recognized abbreviations. Remember that you and other people may need to refer to these notes years in the future. Make sure they are easy to read and understand.

◦ File records promptly and accurately. Establish a strict filing system and adhere to it, and be sure other staff members know the system and importance of using it.

◦ The following guidelines were established for litigation purposes and should be standard practice in all healthcare environments:
   ‣ Alter records as minimally as possible, and only when necessary
   ‣ If you find something in error, do not erase. Cross out the
error using a single line, so as not to conceal what is written underneath, and write the word “error” above the incorrect statement.

- Do not use “white-out”
- If you review your records and feel the need to clarify a point, write the date and the additional comments with the note (labeled “addendum”).
- If litigation is threatened, do not make any kind of change to the records.

Not all file contents are subject to the same retention times. Keep records for current and former clients for as long a period as is practically possible, but at least the length of time specified by federal and state regulations as the legal minimum.

Confidentiality

Keep all original records in your possession. Provide copies of x-rays, notes, and records documenting client care for clients or healthcare facilities requiring their own copies. Share information only in cases where disclosure is required by law, court order, or another appropriate, professionally approved manner, according to legal requirements. Impress the importance of confidentiality and retaining original file copies upon all staff members. Institute the following procedures when providing copies, and make no exceptions:

- Have the client sign and date a release authorization form
- Keep a copy of the release authorization with the client’s records
- Copy only the information requested
- Note in the client’s file: the party requesting the copy, what specifically was requested, and the date, to whom, and where the copy was sent

All information and matters relating to a client’s background, condition, and treatment are strictly confidential and should not be communicated to a third party (even one involved in the patient’s care) without the client’s written consent or a court order. Treat clients with respect and dignity: Handle personal information with sensitivity and keep the content of written records a private matter. Practitioners who can’t resist telling secrets or repeating gossip in their personal lives should be aware of the heavy penalties associated with jeopardizing client confidentiality in a professional context.

Form headings

Heads should easily identify the form, the name of the patient, and the date of each entry (each time the intake form is updated). Every item in the patient’s folder should have identifying information at the top of the form to facilitate filing. Documentation required or associated with health insurance reimbursement must have additional information; typically:

- A claim or identification number assigned to the case.
- A patient’s insurance identification number (ID #).
- The date of the incident, injury, illness, etc.

Use a header that identifies all this information, and/or other ID numbers assigned by the insurance company or another agency, for all forms. Missing information leads to delayed processing. In some cases, however, one of these identification numbers may not be assigned, meaning a blank entry is valid. Intake forms should also include your business name.

New clients

It is generally a good idea to assume that a new client knows nothing about massage therapy. Many massage therapists develop an information sheet to acquaint the client with basic massage concepts.

Office personnel, customary procedures, and other useful points regarding their place of business, such as bathroom locations, and what to expect in a typical session, can be distributed to clients in the waiting room before their first session. Providing basic instructions and answers to common questions in a brief information sheet can be very effective in putting new clients at ease, especially when clients are new to the experience and unfamiliar with a facility’s personnel and way of conducting business.

Uncertainty tends to increase clients’ feelings of vulnerability and loss of control, while familiarity, structure, and predictability tend to increase clients’ feelings of security and comfort, bringing a greater sense of control. Establish a set routine and session protocol to which your clients can grow accustomed. Ideally, sessions should be held at regular intervals, at a single location, for a specific, limited amount of time. Sessions should begin and end punctually, and should not be interrupted by phone calls or intrusions from staff or other clients.

Intake forms

Patients should expect to fill out a number of intake forms related to insurance coverage on their first visit to you. Even before they arrive, you will have completed Form A: Patient Questionnaire, with the patient, over the phone, and confirmed preverification information (Form B). This section will review necessary intake forms and go into further detail regarding documentation required for insurance reimbursement.

Intake forms may include:

**General**
- Patient Information Form (Health History)
- Notice of Informed Consent
- Notice of Release of Medical Records
- Notice of Client’s Bill of Rights
- Fee schedule
- Policies (payment, cancellation, scheduling)
- HIPAA Notice of Privacy Policy

**Insurance-related**
- Health Reporting Forms
- Pain and Disability Questionnaires
- Injury Information Form
- MVA
- Billing Information Form
- HCFA-1500 Form
- Insurance Verification Form

Some practitioners ask the patient come in 15-30 minutes early to fill in the necessary forms. We have found patients take greater care answering the questions if we send some of these forms, like the Patient Information Form (Health History), to the patient in the mail, so he or she can fill it out more leisurely, and, in many cases, more accurately, as he or she can look information up or ask family members to help confirm dates. Many have other health records at home on file to which they can refer to verify dates. Some of the forms, such as the pain questionnaire, must be filled out just before the session, to assess pain or discomfort at that particular moment.

After the patient has provided the information, he/she will mail them back, and you will review the forms with the client in a treatment room or other private area. This discussion should take place before the client changes clothing. Intake forms should be as self-explanatory as possible. When you review the forms with the client, clear up any ambiguities with clarifying questions.

In cases where insurance is paying for a portion or more of the payment, documentation serves another purpose: records must
support or provide justification for both the plan of treatment, in general, and the specific care that day of the session. This entails that documentation supports that the injury was significant, by recording the patient’s symptoms and the deleterious effect or impingement of those symptoms on daily activity. Also, the documentation must support that the treatment being provided has a positive effect, or reduces symptoms, allowing more normal function. If a treatment has a positive effect or reduces symptoms, it is considered reasonable and necessary. Some insurance-related forms will need to be filled out at every session, to chart the progress of the patient.

**Patient information form (health history)**

Every patient should fill out this form on their first visit, and update it yearly to track changes or conditions of concern. Every time the patient visits a clinic, hospital, or another healthcare provider, a record of the visit is made. This information is then compiled into a health or medical record, which used by doctors, nurses, and other medical staff to ensure the patient receives quality healthcare. It serves as:

- Basis for planning care and treatment
- Means by which doctors, nurses, and others caring for patient can talk to one another about needs
- Legal document describing the care received
- Means by which patient or insurance company can verify that services billed were actually provided
- An accurate health history to all healthcare providers who treat the patient

The Patient Information Form (Health History) includes three main areas of information:

- Identification and contact information
- Current health status
- Health history

Identification and contact information should include patient contact information, a person to call in case of emergency, and contact information for the referring health provider, as you may need to call for further information or consent to treat the patient. You will also send copies of progress reports or related information to the patient’s referring healthcare provider.

Current health status and change over time is important in cases of insurance reimbursement. You will want to identify why the patient is coming to you and how you will contribute to their healing. You will want to assess the state of injury, describing its symptoms and the degree to which it impairs normal function. This information is reviewed to validate justification for care. Use the patient’s own words, noted with quotes (“ “), whenever possible. This information from the patient is “subjective” documentation, and is critical in validating care.

Information provided by the healthcare provider, “objective” information, is reviewed and assessed against the subjective information, to corroborate or substantiate treatment for the injury. Objective information is largely recorded in SOAP charting or notes, which will be discussed later. Review the answers to these questions and the client’s medical history with him or her. Ask follow-up questions, as needed, to acquaint yourself with the client’s current state of health and assess potential contraindications to massage.

The Health History includes: (1) a section listing injuries, accidents, illnesses, and surgical procedures in the patient’s history, and (2) a checklist of conditions and symptoms, with a notation regarding if these symptoms or conditions have ever been experienced, when, and if they are being experienced currently. The history should also explore what treatment has been used for conditions or symptoms in the past and currently, including prescription and non-prescription substances the patient is ingesting (such as nutritional supplements or vitamins). Use this information when developing the treatment plan. This way, you can avoid treatments that have proven ineffective or are already being provided by another healthcare provider.

Take the necessary steps to make sure all information is correct and complete. It is useful to have all the information in one place, on this form, which can be used to refer to contact information and develop the treatment plan. You will want to put your name, contact information, and provider number at the top of each page. Make a photocopy of each side and file the form in the client’s chart. Each patient should complete a new health information form at least annually, and more often in cases of progressive or degenerative health conditions, or to note changes in the patient’s health.


**Informed consent, release of medical records, and client’s bill of rights**

The client should also sign and date the following statements:

- Release of medical records
- Notice of informed consent w/scope and limitations of practice
- Client’s Bill of Rights

The concept of informed consent came out of the “patient’s rights” movement of the 1960’s. Now a customary procedure both inside and outside of health and medical care, informed consent refers to a patient’s right to be informed about his or her healthcare or medical condition and participate in decisions regarding that care or condition. The patient, or patient’s guardian, is required to sign a written statement acknowledging agreement to proposed treatment terms and awareness of the known risk factors associated with them.

In massage therapy, informed consent usually takes the form of an agreement between the practitioner and client that states their shared objective, proposed treatment plan, expected outcome(s), and anticipated time-frame for results. It may also refer to the client’s medical history, asserting that the client has informed the practitioner about all known physical or medical conditions and current medications, and will inform the practitioner if any of these conditions change.

The notice of informed consent in massage therapy typically includes a statement explaining the role of massage therapy in pain and stress reduction or other specified purpose, and its limitations: “Massage therapy does not take the place of medical examinations, care, or treatment; the practitioner is not a doctor and does not diagnose medical conditions or prescribe medication; clients should continue to consult their primary caregivers or other specialists for ongoing healthcare and medical conditions. Consult your primary caregiver to review healthcare recommendations before making significant changes in your health and exercise regime or diet.”

Both the practitioner and client are ensured the “right of refusal.” For a client, this means the right to refuse, modify, or terminate treatment regardless of any prior agreements or statements of consent. For a practitioner, this means the right to refuse to treat any person or condition for just and reasonable cause. These rights safeguard a client’s freedom to choose any practitioner, and a practitioner’s freedom to terminate treatment, if necessary. These rights might come into play in cases of negligence or abuse. For example, a
practitioner can refuse to work with an abusive or unstable client, and a client can refuse treatment from a practitioner he or she suspects is practicing under the influence of alcohol, drugs, or any illegal substances.

A Client’s Bill of Rights typically includes the following information:

- Name of practitioner
- Details of practitioner certification and list of credentials
- Practitioner’s area of expertise, philosophy, and/or approach to massage
- Fees and service schedule
- Payment terms
- Filing procedures for written complaints
- A right to information statement, asserting the client’s right to the following information:
  - Practitioner’s assessment of the client’s physical condition
  - Recommended treatment, estimated duration of treatment, and expected results
  - Copy of client’s health forms/records held by practitioner
  - Statement of confidentiality
  - Statement of refusal, explaining the client’s right to terminate a course of treatment at any time and choose a new practitioner
- Clients right to invoke, explaining client’s right to invoke these rights without fear of reprisal

Fee schedule and office policies

The fees schedules typically include the services offered by modality and the fees associated with each. Also include the Current Procedural Terminology (CPT) code for each therapeutic procedure or modality. Care is typically provided in 15-minute increment segments. Only combine times of services that use the same procedural codes.

Some practitioners bill according to time, called “bundling services,” rather than by modality. If you do so, you can use a number of different combinations of manual therapy and charge a flat rate, as long as you do not bundle it with other procedure codes that would be reimbursed at a lower rate than the one you are using to bill the service. In addition, you must bill patients being reimbursed through insurance the same amount you bill other patients for the same services.

Office policies include many different bits of information you want to communicate to the patient: special discounts (for prepayment, for example); billing policies, how a person will be billed, or interest rates on late payments; cancellation policies, such as a requirement for at least 24 – hour-notice on cancelled appointments or other penalties. A written statement of all office policies is typically followed by a signature line. By signing, clients confirm that they have read all office policies and will abide by them.

Notice of privacy practices (HIPAA)

The first-ever federal privacy standards to protect patients’ medical records and other health information provided to health plans, doctors, hospitals and other healthcare providers took effect on April 14, 2003. Developed by the Department of Health and Human Services (HHS), these new standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed.

The Health Information Privacy and Accountability Act (HIPAA) specifies that all healthcare providers must maintain their patient’s privacy. Each patient must receive a written notice stating their right to privacy and explaining the mechanisms for maintaining privacy and the use of their healthcare information. It must also include a statement from you that everything you know about the patient will be kept in strict confidence, although some sharing of information among the insurer, the patient’s doctor, and the attorney, is necessary. The patient should sign the statement confirming he/she has read and understands the privacy policy, and receive a copy of this statement, an example of which is included.

[Medical Center]
Notice of Privacy Practices (HIPAA)

This document is intended to fulfill the notice required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how medical information may be used and disclosed, and how you can get access to this information. Please review it carefully.

We understand that health and medical information is extremely personal. We have a duty, and are committed to protecting health and medical information. When a person is admitted to our facilities, we create a chart and record of the care and services received. We need this record to provide quality care and services, and to comply with certain licensing regulations and other legal requirements. This notice applies to all of the records generated by our facilities when a person is in care with us.

Individually identifiable information about our clients’ past, present or future health or condition, the provision of healthcare, or payment for healthcare is considered “Protected Health Information.” We are required to extend certain protections to this information and to give notice about our privacy practices that explains how, when and why we may use or disclose this information. Except in specified circumstances, we must use or disclose only the minimum necessary medical information to accomplish the intended purpose of the use or disclosure.

We are required to follow the privacy practices as defined in this notice, although we reserve the right to change our privacy practices and the terms of this notice at any time.

How we may use and disclose medical information

We use and disclose personal health information for a variety of reasons. We have a limited right to use and/or disclose such information for purposes of treatment, payment, and to perform our healthcare operations. For uses beyond that, we must have written authorization unless the law permits or requires us to make the use or disclosure without authorization.

Generally, we may use or disclose personal health information as follows:

For treatment

We may disclose personal health information to doctors, nurses and other healthcare personnel who are involved in providing healthcare to a person in our facilities. Health information will be shared among members of the treatment team, medical, psychiatric, psychological and pharmacy personnel. Personal health information may also be shared with outside entities providing ancillary services related to treatment, such as lab work, X-rays, other medical services, outside medical providers, or for consultation purposes. Personal health information may also be shared with family members and community referral agencies involved in the provision, payment, or coordination of care.

For payment

We may use and disclose medical information for payment purposes such as billing a person or an insurance company for services rendered, to obtain prior approval from an insurance company, or for benefit determination.
For health care operations
We may use and disclose medical information for healthcare operations and in the course of operating our facilities and rendering the services we provide. These disclosures are necessary to run our treatment programs and to ensure that our clients receive the highest quality care. We may remove individual identifying information so that others may use information to study healthcare and healthcare delivery without having access to specific personal information. Medical information may also be used for protocol development, case management and care coordination.

For appointment reminders
We may use and disclose medical information to contact you or others involved in the identified person’s care as a reminder for appointments or reviews of treatment or medical care.

For marketing
We will not release personally identifiable information for marketing purposes without prior written authorization.

For research
Under certain circumstances, we may use and disclose medical information for research purposes. Before we use or disclose medical information for research, such a project will have been approved by the agency Director. We will not release personally identifiable medical information without prior written authorization.

As required by law
We will disclose medical information when required to do so by federal, state, or local law, such as by court order, when related to public health issues, when required to do so related to suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity. We must also disclose information to authorities that monitor compliance with these privacy requirements.

When there are risks to public health
We may disclose information to prevent or control disease, injury or disability, report disease, injury, vital events such as birth or death, and the conduct of public health surveillance, investigations and interventions. We may disclose information to report adverse events or product defects. We may disclose information to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.

To avert serious threat to health or safety
We may use and disclose medical information when necessary to prevent a serious threat to the client’s health and safety or the health and safety of the public or another person. Any such disclosure will only be made to parties who can reasonably prevent or lessen the threat of harm or danger.

AUTHORIZATIONS TO USE OR DISCLOSE HEALTH INFORMATION
Other than as stated above, we will not disclose your health information other than with your written authorization. If you or your representative authorizes us to use or disclose your health information, you may revoke that authorization in writing at any time.

Rights regarding client health information
A client served by our facilities has the following rights to their protected health information:

To request restrictions on uses and disclosures
A client has a right to ask that we limit how we use or disclose their protected health information. Such requests should be submitted in writing, and will be responded to within 60 days. We will consider a client’s request, but are not legally bound to agree to the restriction. To the extent that we agree to any restrictions, we will document such agreement in writing and abide by it except in emergency situations. We will not and cannot agree to limit uses or disclosures that are required by law.

To request confidential communication
A client has a right to request that we contact them by means other than phone or mail. We will comply if it is reasonably possible to do so.

To request and inspect a copy of protected health information
Health and medical information generated by our programs is the property of our facilities. However, unless access to records is restricted for clear and documented treatment reasons, a client has a right to see their protected health information upon submission of a written request. Such a request will be responded to within 60 days. If access to records is denied, the client will receive a written statement detailing the reasons for denial and explain any right to have the denial reviewed. If a client wants copies of personal health information, a charge for copying may be imposed, depending on the circumstances. A client has a right to choose what portions of information may be copied, and to have prior notification of charges for copying.

To request amendment of protected health information
If a client believes that there is an error or missing information in our records of personal health information, the client may request, in writing, that we add to or correct the record. The request must include a reason supporting the request to amend information. We will respond within 30 days of receiving the request. The request may be denied if: it is determined that the health information is complete and correct, if the information was not created by us and/or not part of our records, or, not permitted to be disclosed. Any denial will state the reasons for denial and explain the right to have the request and denial, along with any statement in response provided by the client, added to the record. If the request for amendment is approved, we will change the information, inform the client, and inform others needing to know this information.

TO A LIST OF DISCLOSURES
A client may ask for a list of disclosures we made other than for treatment, payment, or healthcare operations, as outlined above. This list will include when, to whom, for what purpose, and what content of protected health information has been released. Such requests should be made in writing and will be responded to within 60 days of the request. The request should specify the time period, and may not be made for periods of time in excess of seven (7) years. We will provide the first accounting requested. Subsequent accounting requests may be subject to a reasonable cost-based fee.

To receive this notice
A client has a right to receive a paper copy of this notice.

Duties of provider
We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our duties and privacy practices. We are required to abide by the terms of this Notice as may be amended from time to time. We reserve the right to change the terms of our Notice and to make the new Notice provisions effective for all health information that we maintain. If we make a material change to this Notice, we will provide a copy of the revised Notice to you or your appointed representative. You or your representative have the right to express complaints as outlined below.
By signing this form, you hereby acknowledge that the [MEDICAL CENTER] may release your Protected Health Information to carry out payment and treatment operations.

EFFECTIVE DATE
[INSERT EFFECTIVE DATE HERE]
I have read and understand the Notice of Privacy Practices of the [MEDICAL CENTER].
Name:______________________________ Date:________________________

How to complain about our privacy practices
If it is felt that privacy rights have been violated, or there is a disagreement about a decision we made about access to protected health information, a complaint may be filed with the person listed below. A complaint may also be filed with the Secretary of the United States Department of Health and Human Services. No retaliatory action will be taken against any party filing a complaint.

CONTACT PERSON TO SUBMIT A COMPLAINT:
[INSERT CONTACT NAME, ADDRESS AND PHONE NUMBER HERE]

Insurance-Related Intake Forms
Health Reporting Forms
Health reporting forms include a variety of documents that assess the status of health, illness, or injury, and follow its progression over time. These documents will be discussed further in the SOAP documenting section. Health reporting forms, for example, might provide patients a means to diagram their locations of pain, stiffness, or numbness, and rate the degree of pain on the day of the session. Patients with chronic conditions or injuries should complete a health report discussing the status of their symptoms or pain on the day of the session, both before and after treatment. Over time, this document will reveal healing or progress from one session to another, showing positive results and justifying the treatment plan.

Measuring pain and disability
Pain and disability questionnaires investigate the patient’s ability to function normally, including sitting, standing, washing, dressing, reading, and any activities he/she participated in before the incident of injury. Degree and proof of injury is assessed along a disability percentage scale, which can be compared at each session to assess progress in healing.

A number of different pain and disability questionnaires exist. Make sure the tools you use are meaningful and accepted by the health insurance agency. Pain and disability indexes record functional progress, which is critical in cases of insurance reimbursement. Functional progress demonstrates improvement in ability and function through the use of reasonable and necessary treatment. It demonstrates that the patient is returning to pre-injury function with the help of the treatment team.

It is important to use the proper measurement device in order to get meaningful data of a patient’s baseline status. The measurement must then be reapplied to get meaningful data of a patient’s improvement. The testing device must be comprehensive enough to give a reliable clinical picture, simple to understand, easy to score, and able to be administered at a low cost. Pain and disability assessments should be administered on a weekly or monthly basis, depending on the frequency of treatment and rate of change. Review this information and assess the degree of impaired function. Any loss should be investigated. Most research instruments provide guidelines regarding the manner and frequency of administration.

Pain questionnaires typically address the following issues:
- Are you experiencing pain/discomfort?
- Where is the location of the pain/discomfort? [Have client mark diagram]
- How and when did the pain/discomfort begin? What were you doing when you first noticed it?
- What level of pain/discomfort are you experiencing? [Use scale from 0 to 10, with “0” meaning “no pain,” and “10” meaning “unbearable pain”]
- Is the pain/discomfort constant, or does it vary in intensity?
- Do you associate the pain/discomfort with a specific movement or activity?
- Have you ever sought medical attention for this condition? [Describe treatment history]
- Do you have tingling, numbness, or pain anywhere else? [Have client mark diagram]

A typical pain and disability questionnaire for the field of Massage Therapy is the revised Oswestry Neck/Back Pain Questionnaire (similar to the Vernon-Mior questionnaire), which can be viewed in full at: http://www.chiro.org/LINKS/outcome.shtml#NDI

There are many different types of instruments used to quantify pain and degree of disability. Because of copyright restrictions, examples of these questionnaires cannot be included here; please refer to the referenced web site above or refer to the list below for further information and detail regarding these research instruments.

Pain questionnaires:
1. Visual Analog Scale [VAS] [Huskisson, 1982]
2. Numerical Pain Scale [NPS] [Jenson, 1986]
3. McGill/Melzak pain questionnaire [Melzack, 1975]
4. Pain drawing [Mooney and Robertson, 1976]
5. Pain Disability Index [Tait, 1987]
6. Dallas Pain Questionnaire [Lawlis, 1989]

Disability: Lower back pain questionnaires:
1. Modified Oswestry Low Back Pain Questionnaire [Fairbank, 1980]
2. Roland-Morris Disability Questionnaire ROL-SIP [Roland, 1983]
3. Low Back Pain Type Specifications [Health Outcomes Institute, 1992]
4. Million Disability Questionnaire [Million, 1982]
5. Waddell Disability Index [Waddell and Main, 1984]

Disability: Cervical or Headache Questionnaires:

Patient Satisfaction Questionnaires:
1. Low Back Pain Patient Satisfaction [Deyo, 1986]
2. Chiropractic Satisfaction Questionnaire [Coulter, 1994]

Personal injury information form(s)
Cases where the patient has experienced an injury or car accident require additional documentation. Different types of insurance are associated with specific types of benefits. In cases of personal injury, you will want to make a distinction between an automobile accident and other types of personal injury. General illness or injury is covered through private insurance or the patient’s employer. Workers compensation covers on-the-job injuries or illnesses. PIP (Personal Injury Protection) covers motor vehicle accidents (MVA).

Because some cases will result in litigation, documentation should be thorough. The insurance company can discontinue care, deny,
and even reverse payment based on documentation alone. Document the mechanics of the injury, symptoms, limited function or activity since the injury, activities affected, complications resulting from the incident, or exacerbated by accident. This information is necessary to substantiate that injuries are significant, were incurred as a result of the incident, and that treatment is justified. Put the same headings on all the injury information questionnaires: name, date, insurance ID number, and the date of injury.

Determine whether another record of the incident exists anywhere, on file. Auto accidents may have been reported to the police. Employees injured in on-the-job incidents should have filed a report with their supervisor. (Individuals injured by MVA while on the job may qualify for both.) While the police report addresses the details of the accident, your documentation should focus on the injury, specifically. Use the injury information questionnaire to describe the onset of the injury, including how and against what the patient fell, for example, not how the accident occurred.

Patients should be as specific as possible describing how the incident or injury occurred and the associated symptoms. Record all symptoms since the incident and establish when they began. Many symptoms are not felt immediately. Track the progression of injuries and healing carefully and accurately, describing limitations in function or daily activities since incident. Both work and nonwork activities should be assessed to determine the significance of the injury. Note any change of duties required for any period of time. Any new inactivity or change in quality of life should also be noted. Be sure to document any work-related impairment for workers’ compensation cases. Confirm the existence of any pre-existing conditions.

All personal injury and workers’ compensation cases should fill out the injury form. Those involved in an auto accident should fill out the motor vehicle accident form. This information is used together with the personal information from the health history to develop an appropriate treatment plan. Injury forms are necessary for reimbursement in workers’ compensation and personal injury cases, as they are used, in part, to assess the significance of injury and support or justify a case for treatment. In general, injury information forms are best filled out at home. Send materials to the individual’s home to fill out before the first session. Then review them with the patient.

The significance or severity of the injury must be established if ongoing treatment is supported to return the individual to pre-injury state. Some items such as visual disturbances or loss of memory are easily forgotten compared to the more obvious bruises or cuts, so these issues are prompted with standard questions. Some of the questions on the injury information form are associated with specific types of injury, such as whiplash trauma. Breathing difficulties can relate to seat belt injuries.

External proof of impact is supportive information for the case of treatment, so pictures and descriptions of visible injury, like cuts and bruises, can be used to support the patient’s treatment. Always include a section, in your questionnaire, asking the individual if he/ she has anything else to add, in case your form does not address every contingency or issue the patient considers important.

The patient should list all care related to the incident or injury and all healthcare providers involved to avoid duplication of treatment and facilitate treatment coordination. Include the primary healthcare provider’s (HCP) diagnosis. According to Diana L. Thompson, an expert in insurance reimbursement for massage therapy:

“Typically, insurance peer reviewers red-flag a case if manual therapy is the only source of treatment, unless the manual therapist has primary care status. The combination of allopathic and complementary care is more acceptable. Noting additional care may help justify the treatment and speed up claims processing.”

The following information can be distributed to your patient to help explain the process of billing for the purposes of insurance reimbursement:

**Personal injury and insurance**

Coverage for personal injury (PI) claims can be very complicated. Our office follows the following progression of claim submission. If your claim is automobile related and you have automobile insurance with medical pay benefits, we will bill all charges to your automobile insurance.

If no automobile insurance is available or medical pay benefits are exhausted, claims will be sent to your health insurance. If your health insurance does not cover chiropractic or if you have a deductible and co-payments, we ask that you make payments at the time of service. You may be able to recover these payments from your automobile insurance or the other responsible (third) party’s insurance.

If no insurance is available or claims are being billed to a third party’s insurance, we ask that you make payments at the time of service. You may be able to recover these payments from the third party’s insurance.

If you have retained an attorney to help you with your PI case, please inform our office. We will gladly work with most attorneys, and in approved cases, may wait until settlement for payment. If our office cannot obtain the proper paperwork from your attorney to guarantee payment at settlement, we will require payment at the time of service. Unfortunately, our office has had difficulty with reimbursement from a few law offices and will require payment at the time of service if you have retained one of these firms. If you have questions about how your case may be handled with your attorney, please ask our staff. Regardless of the billing situation your PI claim involves, please remember that you are ultimately responsible for the full payment of your account. Please read all forms carefully to be sure you understand how your case will be handled.

**Worker’s compensation**

If you are injured at work or become ill because of what you think is a work – related exposure, you must report the accident, incident or exposure to your supervisor. Any delays in reporting an accident, incident, or exposure may affect not only your health but your compensation benefits as well.

It is the responsibility of your supervisor or manager to fill out an injury report, which must be reported to the state Worker’s Compensation Division. You are entitled to your own copy.

The WC Division will assign your case a claim number. Please retain this number until your WC claim settles.

Your employer may choose which provider you see for your work injury. You also have the right to select a doctor, chiropractor, psychologist or dentist licensed in the state. You are responsible for notifying your employer of who you have selected.

When you arrive for the first time for an appointment, you will be asked for your WC claim # and your health insurance card.
The doctor’s office will contact your employer to confirm your work has accepted liability for the claim.

Once you have seen the doctor, the employer, the insurer, and you may view medical records.

All claims will be processed through the carrier identified by your employer.

You may file a hearing with the Division of Workers Compensation:

- If your employer fails to report an injury
- If there is any dispute over any claim between you and your employer
- If there is a dispute between you and the insurer that cannot be resolved by talking it over

If, for some reason, your claim is not covered by worker’s compensation, we will submit it to your regular health insurance payer.

**ON-THE-JOB INJURY QUESTIONNAIRE**

**TODAY’S DATE:** _______/_______/_______

**FIRST MIDDLE INITIAL LAST NAME:** ______________________________________________

**ACCIDENT DATE:** _______/_______/_______

**TIME OF ACCIDENT:** _______:_______ AM PM

**HOW DID THE INJURY OCCUR?** ______________________________________________________

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**WAS A WORK INCIDENT REPORT FILED WITH YOUR SUPERVISOR?** □ YES □ NO

**MAY I CALL YOUR EMPLOYER FOR TREATMENT AUTHORIZATION?** □ YES □ NO

**DO YOU HAVE A WORKERS’ COMPENSATION ATTORNEY?** □ YES □ NO

**IF YES, PROVIDE NAME AND PHONE CONTACT INFORMATION:** __________________________

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**DID YOU HAVE ANY PHYSICAL COMPLAINTS BEFORE THE INCIDENT?** □ YES □ NO

**IF YES, DESCRIBE:** ______________________________________________________________

**DO YOU HAVE ANY ILLNESSES OR PREVIOUS INJURIES THAT MAY HAVE BEEN AFFECTED BY THIS INJURY?** □ YES □ NO

**IF YES, DESCRIBE:** ______________________________________________________________

**DESCRIBE ANY BRUISES, CUTS, OR ABRASIONS AS A RESULT OF THE INJURY:** __________________________

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**DID YOU FEEL PAIN IMMEDIATELY?** □ YES □ NO

**IF YES, WHERE?** __________________________

**IF NO, WHEN DID YOU START FEELING ONSET OF SIGNS AND SYMPTOMS? DATE _______/_______/_______

**(CIRCLE ONE) SUN MON TUE WED THU FRI SAT SUNDAY** _______:_______ HOURS AFTER ACCIDENT

**INITIAL SIGNS AND SYMPTOMS:** ______________________________________________________

**NUMBNESSTINGLING IN:** ___________________________________________________________

**PAIN/STIFFNESS IN:** ______________________________________________________________

**OTHER SYMPTOMS EXPERIENCED SINCE THE INCIDENT?** __________________________________

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**SINCE THE INJURY, SYMPTOMS ARE:** 

□ WORSE □ IMPROVED □ CHANGED □ NO CHANGE

**DESCRIBE:** ______________________________________________________________

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**DOES ANYTHING RELIEVE YOUR SYMPTOMS?** __________________________

**DOES ANYTHING AGGRAVATE YOUR SYMPTOMS?** __________________________

**AFTER INCIDENT I WENT:** _____HOME _____HOSPITAL

**(CIRCLE ONE) _____ASAP _____ LATER VIA: _____ AMBULANCE _____ CAR HOSPITAL PROCEDURES:**

□ X-RAYS □ LABORATORY TESTS □ OTHER:

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**HOSPITALIZATION:** ______________________________________________________________

**PRESCRIPTION:** ______________________________________________________________

**INSTRUCTIONS:** ______________________________________________________________

**WENT TO DOCTOR’S OFFICE:** ___________________________________________________

**DR NAME:** __________________________

**DATE:** _______/_______/_______ **TIME:** _______:_______ AM PM

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**OTHER HEALTH CARE PROVIDERS WHO HAVE TREATED YOU FOR THIS INJURY:**

**NAME:** ______________________________________________________________

**TYPE OF TREATMENT:** _________________________________________________________

**DIAGNOSIS:** ______________________________________________________________

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**HAVE YOU LOST TIME FROM WORK SINCE THE INJURY?** □ YES □ NO

**HAVE YOUR WORK RESPONSIBILITIES CHANGED AS A RESULT OF THE INJURY?** □ YES □ NO

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**RESTRICTIONS DUE TO THE INJURY OR CONDITION (CHECK ALL THAT APPLY, SPECIFY POUNDS AND FREQUENCY AS APPROPRIATE, AND EXPLAIN):**

**LIFTING:** ______________________________________________________________

**PUSHING/PULLING**

**BENDING/STOOPING**

**KNEELING; SQUATTING**

**TWISTING**

**USE OF EXTREMITIES**

**STANDING**

**WALKING**

**SITTING**

**REPETITIVE MOTIONS**

**DRIVING**

**VIBRATIONS**

**LIMBING**

**SPLINTS/CRUTCHES/BANDAGES**

**OTHER CONDITIONS (E.G., DRY WORK ONLY; NO HEAT EXPOSURE, ETC.):** ______________________________________________________________

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**WHAT OTHER WORK ACTIVITIES ARE AFFECTED BY THIS INJURY?** __________________________

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HAVE YOU INJURED THIS AREA BEFORE?  Yes  No

IF YES, WHEN?

DID YOU LOSE TIME FROM WORK?  Yes  No

DO ANY OTHER MEDICAL ISSUES AFFECT YOUR ABILITY TO WORK?  Yes  No

DURING NORMAL ACTIVITIES, DO YOU FAVOR ANY PART OF THE BODY?  Yes  No

IF YES, DESCRIBE:_________________________________________

HAVE YOU EVER FILED A WORKERS’ COMPENSATION CLAIM BEFORE?  Yes  No

ARE YOU STILL EMPLOYED BY THE SAME COMPANY?  Yes  No

ARE YOU CURRENTLY WORKING?  Yes  No

IF NO, LAST DATE OF EMPLOYMENT: ____________________

IF WORKING FOR A DIFFERENT COMPANY, PROVIDE NAME:________________________________________________

PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT OR SIGNIFICANT ABOUT THE INCIDENT: ____________________

AUTO INJURY QUESTIONNAIRE (MV A)

TODAY’S DATE: __________/__________/__________

NAME:_________________________________________________

FIRST MIDDLE INITIAL LAST

ACCIDENT DATE: _____/_____/_____

TIME OF ACCIDENT: ___:___ AM PM

PATIENT: _____ DRIVER _____ PASSENGER _____ PEDESTRIAN _____ MOVING _____ STOPPED

IF DRIVER AND STOPPED, WAS YOUR FOOT ON THE BREAK?  Yes  No

ESTIMATED SPEED :_______ MPH

WERE YOU? _____ INCREASING SPEED _____ DECREASING SPEED _____ AT STEADY SPEED

ROAD CONDITION(S): ___DRY ___DAMP ___WET ___RAIN ___ICE ___ SNOW

WERE YOU STRUCK FROM? ___ BEHIND ___FRONT ___ RIGHT SIDE ___LEFT SIDE

HOW WAS YOUR VEHICLE HIT? ___HEAD ON ___REAR END ___ SIDE SWIPE

DESCRIBE_____________________________________________

IF YOU WERE HIT FROM BEHIND, WAS YOUR VEHICLE PULLED FORWARD UPON IMPACT?  Yes  No

IF YES: HOW FAR:______________________________________

WHERE WERE YOU SEATED IN THE VEHICLE?

DID YOUR VEHICLE HIT ANOTHER VEHICLE/OBJECT?  ___ HEAD ON ___REAR END ___ SIDE SWIPE

DESCRIBE:_____________________________________________

IF YES, WAS IT: _____ INCREASING SPEED _____ DECREASING SPEED _____ AT STEADY SPEED

HEAD REST: ___NONE ___ INTEGRAL ___ ADJUSTED IN POSITION

DOES YOUR HEAD TOUCH THE HEADREST?  Yes  No

IF NO, HOW FAR IN FRONT OF THE HEAD REST IS YOUR HEAD?

DID ANY PART OF YOUR BODY COME INTO CONTACT WITH THE VEHICLE?  Yes  No

IF YES, DESCRIBE:

DESCRIBE ANY BRUISES, CUTS, OR ABRASIONS AS A RESULT OF THE INJURY:_____________________________________________

SEAT BELT: _____ WEARING _____ NOT WEARING

SHOULDER HARNESS: _____ WEARING _____ NOT WEARING _____ WEARING BOTH

IS YOUR VEHICLE EQUIPPED WITH AN AIRBAG?  Yes  No

DID AIRBAG ACTIVATE?  Yes  No

HEAD POSITION:  ___FACING FORWARD ___FACING LEFT ___FACING RIGHT

HANDS:  ___ONE ON WHEEL ___TWO ON WHEEL

AWARE OF IMPENDING COLLISION:  Yes  No

FELT BODY GO:  ___FORWARD ___BACKWARD ___SIDEWAYS ___OTHER

SECOND COLLISION IN VEHICLE?  Yes  No

IF YES, EXPLAIN________________________________________

SECOND COLLISION OUTSIDE OF VEHICLE?  Yes  No

IF YES, EXPLAIN

OTHER(S) IN YOUR CAR:  D=DRIVER  P=PASSENGER

WEARING GLASSES:  Yes  No

GLASSES STILL ON AFTER COLLISION:  Yes  No

LOSS OF CONSCIOUSNESS:  Yes  No

DID YOU FEEL PAIN IMMEDIATELY?  Yes  No

IF NO, WHEN DID YOU START FEELING ONSET OF SIGNS AND SYMPTOMS: DATE_____/_____/_____

(CIRCLE ONE) SUN MON TUE WED THU FRI SAT _____ HOURS AFTER ACCIDENT

INITIAL SIGNS AND SYMPTOMS:  _____ NONE  _____ HEADACHE  _____ DIZZINESS  _____ DISORIENTATED  _____ SHOCK

NUMBNESS/TINGLING IN:  _____ ARMS  _____ LEGS

OTHER: ______________________________________________

NECK PAIN/STIFFNESS  _____ UPPER BACK PAIN/STIFFNESS  _____ MIDDLE BACK PAIN/STIFFNESS  _____ LOWER BACK PAIN/STIFFNESS
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SINCE THE ACCIDENT?

- Memory loss
- Loss of balance
- Disturbed vision
- Hearing impairment
- Breathing difficulty
- Sleep disturbances

SINCE THE INJURY, SYMPTOMS ARE:

- Worse
- Improved
- Changed
- No change

DESCRIBE:

DID THE POLICE ARRIVE AT THE ACCIDENT? ☐ Yes ☐ No

AFTER ACCIDENT I/WE WENT: ☐ Home ☐ Hospital

HOSPITAL PROCEDURES: ☐ X-rays ☐ Laboratory

TESTS ☐ Collar

PRESCRIPTION: ___________________________________________

DIAGNOSIS: ______________________________________________

INSTRUCTIONS: __________________________________________

WENT TO DOCTOR’S OFFICE:

DR NAME: _______________________________________________

DATE: ______/_____/______ TIME: ________ AM PM

POLICE INVOLVED: ☐ Yes ☐ No

REPORT FILED: ☐ Yes ☐ No

BRAKES: ☐ On ☐ Off

TRANSMISSION: ☐ Manual ☐ Automatic

TYPE OF CAR: YEAR _____ MAKE__________ MODEL_______

OTHER CAR(S) INVOLVED: YEAR_____MAKE_____MODEL__

LOCATION OF IMPACT: ☐ Front ☐ Back ☐ Right side ☐ Left side

ESTIMATED PROPERTY DAMAGE $__________

VEHICLE: ☐ Drivable ☐ Not Drivable

PRIOR MEDICAL CARE AND DOCTOR: _______________________

X-RAYS DATE ______/_____/______

PRIOR CHIROPRACTIC CARE AND DOCTOR: _______________________

X-RAYS DATE ______/_____/______

PREVIOUS MOTOR VEHICLE INJURIES

DATE ______/_____/______

PREVIOUS WORKERS’ COMPENSATION INJURIES:

DATE ______/_____/______

PREVIOUS SPORTS INJURIES

DATE ______/_____/______

PLEASE DRAW THE ACCIDENT SCENE

INSURANCE QUESTIONS:

DO YOU HAVE NO-FAULT PIP? ☐ Yes ☐ No

BENEFITS OR MED-PAY? ☐ Yes ☐ No

ARE BENEFITS EXHAUSTED? ☐ Yes ☐ No

DO YOU HAVE A DEDUCTIBLE? ☐ Yes ☐ No

IF YES, HOW MUCH?

HAS THE DEDUCTIBLE BEEN MET? ☐ Yes ☐ No

IF NO, HOW MUCH IS LEFT TO PAY?

AFTER THE DEDUCTIBLE IS MET,

WHAT PERCENTAGE DOES YOUR INSURANCE COVER? ________%

WHAT ARE THE POLICY LIMITS? ______________________

DO YOU HAVE U/M (UNINSURED MOTORIST PROTECTION) ☐ Yes ☐ No

WERE YOU CITED IN THE ACCIDENT? ☐ Yes ☐ No ☐ Unsure

PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT OR SIGNIFICANT ABOUT THE INCIDENT: __________________________________________

____

FILL IN THE INFORMATION BELOW FOR THE DRIVER OF VEHICLE AT FAULT:

NAME ______________________ HONE ______________________

ADDRESS ______________________________________________

_______________________________________________________

POLICY NUMBER: _________________________________________

ATTORNEY NAME: ________________________________________

PHONE: __________________________________________________

PERSONAL INJURY QUESTIONNAIRE

TODAY’S DATE: ______/_____/_______

NAME: _________________________________________________

FIRST MIDDLE INITIAL LAST

ACCIDENT DATE: ______/_____/_______

TIME OF ACCIDENT: ________:_______ AM PM

HOW DID THE INJURY OCCUR?

_______________________________________________________

DO YOU HAVE AN ATTORNEY? ☐ Yes ☐ No

IF YES, PROVIDE NAME AND PHONE CONTACT INFORMATION _______________________________________

_______________________________________________________

DID YOU HAVE ANY PHYSICAL COMPLAINTS BEFORE THE INCIDENT? ☐ Yes ☐ No

IF YES, DESCRIBE:

_______________________________________________________

DO YOU HAVE ANY ILLNESSES OR PREVIOUS INJURIES THAT MAY HAVE BEEN AFFECTED BY THIS INJURY? ☐ Yes ☐ No

IF YES, DESCRIBE _______________________________________

_______________________________________________________

DESCRIBE ANY BRUISES, CUTS, OR ABRASIONS AS A RESULT OF THE INJURY:

_______________________________________________________

DID YOU FEEL PAIN IMMEDIATELY? ☐ Yes ☐ No

IF YES, WHERE?

IF NO, WHEN DID YOU START FEELING ONSET OF SIGNS AND SYMPTOMS: DATE ______/_____/_______

(CIRCLE ONE) SUN MON TUE WED THU FRI SAT

______HOURS AFTER INCIDENT

INITIAL SIGNS AND SYMPTOMS:

NUMBNESS/TINGLING IN: _______________________

PAIN/STIFFNESS IN: _______________________

OTHER SYMPTOMS EXPERIENCED SINCE THE INCIDENT:

_______________________________________________________

_______________________________________________________

SINCE THE INJURY, SYMPTOMS ARE:

WORSE _____IMPROVED _____CHANGED _____NO CHANGE

DESCRIBE:

_______________________________________________________

_______________________________________________________

18
DOES ANYTHING RELIEVE YOUR SYMPTOMS? 

DOES ANYTHING AGGRAVATE YOUR SYMPTOMS? 

AFTER INCIDENT I WENT: ____ HOME ____ HOSPITAL 
____ ASAP ____ LATER VIA: _____ AMBULANCE _____ CAR 

HOSPITAL PROCEDURES: ____ X-RAYS ____ LABORATORY 
TESTS 

OTHER: 

HOSPITALIZATION: 

DIAGNOSIS: _______________________________________

TYPE OF TREATMENT: ________________________________

NAME: ___________________________________________________

DIAGNOSIS: ___________________________________________

DATE: _____/_____/_____ TIME_____:_____ AM PM 

OTHER HEALTH CARE PROVIDERS WHO HAVE TREATED 
YOU FOR THIS INJURY: 

NAME: 

TYPE OF 
TREATMENT: 

NAME: 

DIAGNOSIS: 

HAVE YOUR WORK RESPONSIBILITIES 
CHANGED AS A RESULT OF THE INJURY?  ☐ YES ☐ NO 

HAVE YOUR DAILY ACTIVITIES CHANGED AS A RESULT 
OF THE INJURY?  ☐ YES ☐ NO 

RESTRICTIONS DUE TO THE INJURY OR CONDITION 
(CHECK ALL THAT APPLY, SPECIFY POUNDS AND 
FREQUENCY AS APPROPRIATE, AND EXPLAIN): 

LIFTING: 

PUSHING/PULLING 

BENDING/STOOPING: 

KNEELING; QUATTING: 

TWISTING: 

USE OF EXTREMITIES: 

STANDING: 

WALKING: 

SITTING: 

REPETITIVE MOTIONS: 

DRIVING: 

VIBRATIONS: 

LIMBING: 

SPLINTS/CRUNCHES/BANDAGES: 

OTHER CONDITIONS (E.G., DRY WORK ONLY; NO HEAT 
EXPOSURE, ETC.): 

WHAT OTHER WORK ACTIVITIES ARE AFFECTED BY THIS 
INJURY? 

HAVE YOU INJURED THIS AREA BEFORE? ☐ YES ☐ NO 

IF YES, WHEN? 

DURING NORMAL ACTIVITIES, DO YOU FAVOR ANY PART 
OF THE BODY? ☐ YES ☐ NO 

IF YES, DESCRIBE: 

PLEASE ADD ANYTHING YOU FEEL IS 
IMPORTANT OR SIGNIFICANT ABOUT THE 
INCIDENT: 

Billing information form 
The three following forms, the Billing Information Form, the 
Insurance Verification Form, and the HCFA 1500, which is the basic 

health insurance form used by insurance companies, are all closely 
associated with the approval process. The Billing Information Form 
duplicates the first part of the HCFA 1500, with identification and 
contact information for the patient and the injured, if different, and 
details regarding primary and secondary insurance coverage. 

You will need to collect contact information for the patient, insurance 
companies and representatives, the attorney, and the primary 
healthcare provider. Patients involved in auto accidents may retain 
an attorney, who may review or collect the bills from all healthcare 
providers before sending them on to the insurance company. 
Therefore, you may need the attorney’s address and contact 
information to coordinate bill payment, and keep him/her apprised 
of billing status. Attorneys may ask the patient to sign an exclusive 
medical release of healthcare document to prevent the insurance 
company of the at-fault individual from obtaining information 
without knowledge and consent of the attorney. In that case, all 
signatures releasing medical forms are made null and void. 

Billing authorization statements authorize the insurance company 
to pay the provider directly and authorize the provider to release 
medical records to the insurance company in order to process claims. 

Some people also include a short form of HIPAA with a release of 
records and an additional payment agreement with terms of payment 
accepted. 

The final part of the Billing Information Form is a section with three 
statements that must be signed to show authorization by the patient. 
The statement of financial responsibility is included here to remind 
patients they are ultimately financially responsible for services. This 
statement should include any terms of payment or penalties for late 
fees, etc. The patient signs to confirm he/she is aware of the terms of 
payment and penalties. 

Billing Information Form 

Patient Information: 

Name: _______ 

Address: _______ 

Phone 1 (____) _______ Phone 2 (____) _______ Phone 3 (____) _______ 

Social Security Number: _______ Date of Birth: _______ 

Gender: M F Marital Status: S M 

Employed: _____ full time _____ part time _____ retired _____ unemployed 

Student: _____ full time _____ part time 

Employer and/or School Name(s): _______ 

Address: _______ Fax: _______ 

Injury Information: 

Patients condition is related to: _____ employment _____ auto accident 
_____ illness _____ other 

If auto accident, provide state: _______ 

If other, describe: _______ 

State of occurrence: If gradual, date of first Dr appt: _______ 

If injury, date of injury: _______ 

Dates unable to work, if any: from: _______ to _______ 

Date of emergency room visit, if any: _______ 

Hospitalization, if any: from: _______ to _______ 

Primary Health Care Provider/Prescribing Physician 

Name: _______ 

Address: _______ 

Phone: _______ 

Fax: _______ 

Physician ID# _______ 

Diagnoses/Number of visits prescribed by Dr: _______
**Insurance information:**
Workers Compensation: Employer at time of Injury: ____________________________
Address: ____________________________
Phone: ____________________________ Fax: ____________________________
Relationship of patient to the insured: __ self __ spouse __ child __ other

**Fill in the following for insured if different from patient:**
Name: ____________________________
Address: ____________________________
Phone 1 (___)______ Phone 2 (___)______ Phone 3 (___)______
Social Security Number: ____________________________ Date of Birth: ____________________________
Gender: M F Marital Status: S M
Employed: __ full time __ part time __ retired __ unemployed
Student: __ full time __ part time __
Employer and/or School Name(s): ____________________________
Address for billing/claims: ____________________________
Fax: ____________________________
Phone: ____________________________

**Primary Insurance Coverage:**
Insurance Company Name: ____________________________
Address for billing/claims: ____________________________
Adjustor/Contact: ____________________________
Phone: ____________________________ Fax: ____________________________
Insured’s ID Number: ____________________________
Claim or Case Number: ____________________________
Policy/Group Number: ____________________________
Plan Name or Number: ____________________________
Number of visits authorized by insurance: ____________________________

**Secondary Insurance Coverage:**
Insurance Company Name: ____________________________
Address for billing/claims: ____________________________
Adjustor/Contact: ____________________________
Phone: ____________________________ Fax: ____________________________
Insured’s ID Number: ____________________________
Claim or Case Number: ____________________________
Policy/Group Number: ____________________________ Plan Name or Number: ____________________________
Number of visits authorized by insurance: ____________________________
Attorney: ____________________________
Name: ____________________________
Address: ____________________________
Phone: ____________________________ Fax: ____________________________

**ASSIGNMENT OF BENEFITS:**
To the Insurance Company, ____________________________
By signing below, I authorize and direct payment of medical benefits for services billed to my healthcare provider. I instruct you to make payment directly to the provider for medical claims submitted by them on my behalf for medically necessary treatment. This will also serve as a “Limited Power of Attorney.” Please provide them all information related to my insurance coverage and benefits.

**Release of records per HIPAA privacy statement:**
To the Health Care Provider, ____________________________
By signing below, I authorize that I have read and understood the Privacy Practices under HIPAA, and authorize you to release to any attorney, healthcare provider, or insurance company agents involved in the case, any medical or other records, including intake forms, chart notes, reports, and billing statements or any other information necessary to process my claim. I understand these records may be used for the recovery of benefits. I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney.

**Payment agreement**
It is my responsibility to pay for all services provided. In the case that my insurance company denies payment or makes only a partial payment, I agree and acknowledge that I am responsible for paying the balance.

Patient Signature: ____________________________ Date: ____________________________

**The insurance verification/benefit authorization form**
The Insurance Verification/Benefit Authorization Form puts much of the insurance information in one detailed document. You may already have some of this information filled out from the preverification process. Even so, it is best to reconfirm all information to ensure it is still valid. You will likely use this form to find contact information for the referring or primary healthcare provider, attorney, and the insurance company representative or human resources personnel, for the patient’s employer. Complete the form for any patient seeking insurance reimbursement.

Regarding employment: If insurance coverage is through the patient’s job (either workers’ compensation or a group health insurance plan) you must verify that the patient is employed and eligible for benefits. You will verify eligibility through the patient’s insurance representative first. If you cannot verify eligibility through the insurance representative, contact a human resource representative or benefits’ administrator at the patient’s place of work. Ask whether the patient is currently employed, their length of time at the company, when insurance coverage became effective, and when it expires. Some information does not apply to all types of coverage. If any area does not apply, cross it out and write NA (not applicable) in the space.

You will want to reconfirm that manual therapy is a benefit in the patient’s plan of coverage. Ask if massage therapy, specifically, is covered. If manual therapy is covered, ask who can provide the service. Reconfirm that you are eligible to provide this service. You will likely need preferred provider status or have a provider number to be eligible for payment. In some cases, manual therapy is only available if provided by a nurse or doctor. You will need to specifically confirm your title and relationship to the HCP in cases where you are billing under the license of a primary healthcare provider.

Confirm eligibility including the specific ICD codes or the diagnosis from the prescription. In cases where the HCP wrote information without providing the ICD code, and the insurance company requires an ICD code to be identified on the billing form, call the HCP and get the relevant ICD code.

If a diagnosis code is not authorized, ask for clarification as to the reason. In some cases, a code is too specific, or for some other reason is not considered an authorized diagnosis for the treatment. In that case, use a general ICD code. If a code is denied, ask the insurance representative for a list of the permitable codes for the condition. Then, as long as you do not misrepresent the patient’s diagnosis, you can call the referring HCP to request that a different diagnosis code be written on the prescription.

Reconfirm that the specific treatment you supply is a covered benefit. As you work with this information, you will learn what manual therapy procedural codes fall within your scope of practice as a massage therapist. Patient’s insurance plan may not reimburse for all the codes available for you to use. Check each CPT code with each different insurance plan. If you are a contracted provider, the reimbursable codes will be specified in your fee schedule. In those cases, fill in this section’s information according to the terms in your
As the insurance representative from each company the following questions regarding CPT codes listed:
- Is the code reimbursable under the patient’s plan?
- Am I eligible to provide this service?
- Are there any restrictions or exclusions for the code?
- Is there a limit to the reimbursable amount per unit of time (fee cap)?
- Is there a limit to the amount of time I can bill for each session (unit cap)?

Note if there are any limits, either on the total number of sessions, or the total dollar limit for manual therapy for a policy year. Usually plans limit care to a number of visits per year or coverage up to a certain amount. Each year, the benefits are renewed when the policy is renewed.

Managed care usually requires a deductible that the patient pays out-of-pocket before coverage of any kind begins. Find out whether a deductible applies to your services, the amount, and if any portion of it has been paid yet. If it has not, the patient should pay the deductible at the time your services are rendered. Submit patients’ bills to the insurance carrier, showing the amount paid so the payments can be put toward the deductible. Once the deductible is paid, payment should be directed to the insurance company. Also find out when the policy is due for renewal, as the deductible will need to be paid again.

Most healthcare plans require a “co-pay”, a portion of the healthcare visit due the day service is provided. Co-pays must be collected from the patient on the day of service. Do not fail to collect the co-pay as some insurance providers consider it a breach of contract. Other plans require a co-insurance payment, rather than a co-pay. Co-insurance is a percentage of the service fee, rather than a set fee. It must be collected from the patient at the time of service.

Ask the insurance representative for verbal authorization to provide services to the patient. Request an authorization number for services, and verify the number of sessions authorized and dates for providing service. In most cases, you will have to authorize services at one point, then authorize payment once the bills have been submitted. Verify the reauthorization date: If ongoing treatment is necessary, when should re-authorization occur so there is no gap in service?

Confirm that bills should be submitted on a HCFA 1500 form. Most insurance companies prefer electronic billing, and will provide a link to their on-line form. Check whether copies of the patient’s file should be sent with the bills. If so, what specifically should be copied. It is useful to ask the estimated turnaround times for payment and any special requirements of the insurance company.

Send a confirmation letter, reviewing authorization of services. Include a copy of the insurance verification form. If a claim is completely and accurately filed out, verbal authorization is sufficient for reimbursement. However, the confirmation letter insures that the insurance company has the authorization on file. Note the date the letter was sent on the verification form before sending a copy. Repeat all verification info when you require reauthorization for further services or treatment.

On the insurance verification form, date and initial each piece of information as you fill it out (it may take more than one day). In cases of personal injury, contact the attorney if one has been retained. If the patient has not retained an attorney, ask for a copy of the car insurance policy and contact the insurance claims adjustor to verify patient information.

Document any information about healthcare liens and attorney liens. If PIP, Med Pay, or secondary coverage does not exist or is exhausted, you can file liens on the patient and attorney according to the laws of your state. Health care liens may need to be renewed before the expiration date, so note the date filed and dates renewed in your notes. (Typically, one should note the date the guarantee was requested from the attorney, and the date returned and filed. Note expiration dates wherever applicable. If the secondary coverage is the patient’s health insurance, fill out the benefit authorization section as well as secondary coverage section.

If a motor vehicle accident occurred while the patient was on the job, fill out employer information. Otherwise, employment and benefit information does not apply to personal injury cases.

For PIP or Med Pay coverage, note the total amount of the benefit and the dates it is available and the amount currently available. You may need to speak with the patient, the insurance carrier, and/or the attorney to fully investigate the exact amount of benefits available. In many cases, you will need the patient to ask the insurance carrier representative directly, as he or she is not authorized to divulge this information to you.

**Verification of Insurance Coverage/Benefit Authorization Form**
(Complete one form for each incident)

**Section I:** (Confirm as much of Section I as you can using form A or speaking to the patient directly, before speaking to the insurance company representative)

Date: ______________ Time of Call: ______________

Insurance Company Name: __________________________

Phone #: __________________

Adjustor/Claim Rep Name: __________________________

Patient’s Name and Social Security Number:

Name __________________________

SS# __________________________

Insured’s Name and Social Security Number:

Name __________________________

SS# __________________________

If Workers’ Compensation, Employer Name and Phone Number:

Name __________________________

Phone __________________________

Date of Injury/Illness: ______________

Case or Group Number: ______________

Claim Number: ______________

Insurance Identification Number:

**Section II** [Refer to the Patient Information Form (Health History), or ask the Insurance Representative, Patient, and/or Attorney’s Office to fill out this section.]

**Patient Employment:**

Employer: __________________________ Phone/Fax: ______________

Contact name: __________________________ Title: __________________________

Currently employed? [ ] Yes [ ] No

Effective date of benefits: ______________ Expiration date of benefits: ______________

Verification date: ______________ Time: ______________

**Primary Health Care Provider:**

Name: __________________________ Title: __________________________
Attending provider for this injury/illness? [ ] Yes [ ] No
Referring provider for massage/manual therapy? [ ] Yes [ ] No
Prescription received? [ ] Yes [ ] No
If yes, Date:
Tx duration/frequency:
Diagnosis [ICD-10 Code(s)]:
1st renewal date: _____________________________ Number of Tx: __________________________
Tx duration/frequency:
2nd renewal date: _____________________________ Number of TX: __________________________
Tx duration/frequency:
3rd renewal date: _____________________________ Number of TX: __________________________
Tx duration/frequency:

Attorney:
Name of Firm: ___________________________________________ Phone: __________________ Fax: __________________
Name of Attorney: ______________________________________ Phone: __________________ Fax: __________________
Other Contact (i.e., secretary or paralegal)
Name and Title:

Guarantee of Payment filed? [ ] Yes [ ] No
If yes, Date: __________________________
Medical Lien filed? [ ] Yes [ ] No
If yes, Date: __________________________
Medical Lien renewed? [ ] Yes [ ] No
If yes, Date: __________________________
Copy of patient file:
1st date requested: __________________________ Date sent: __________________________
2nd date requested: __________________________ Date sent: __________________________
3rd date requested: __________________________ Date sent: __________________________

Section III (You will fill out most of Section II and Summary by contacting each Insurance Company)

Insurance:
Private Health Insurance
Verification Date: __________________________ Time: __________________________
Company Name: __________________________________ Phone: __________________ Fax: __________________
Contact Name: __________________________ Title: __________________________
Worker’s Compensation (L&I)
Verification Date: __________________________ Time: __________________________
Company Name: __________________________________ Phone: __________________ Fax: __________________
Contact Name: __________________________ Title: __________________________

Personal Injury Insurance
Primary Insurer:
Adjuster: __________________________
Billing Address: __________________________________ Phone: __________________ Fax: __________________
Verification Date: __________________________ Time: __________________________
Policy coverage dates:
PIP amount on policy: $________ PIP still available $________
Med Pay coverage dates:
Med Pay amount on policy: $________ Med Pay still available $________

3rd party Insurer
Billing Address:
Adjuster: __________________________
Phone: __________________ Fax: __________________
Verification Date: __________________________ Time: __________________________
Policy coverage dates:
Liability policy amount: $________ amount available: $________
Uninsured/underinsured Motorist (UIM): $________
Policy amount: $________ UIM available: $________

1. Is manual therapy a benefit covered by the patient’s policy?
[ ] Yes [ ] No
2. Is the patient eligible for the manual therapy benefit? [ ] Yes [ ] No
[Will need diagnosis and ICD-10 codes]
3. Am I eligible to provide the manual therapy services? [ ] Yes [ ] No
[Provide professional license/certification information]
   - If an answer above is “no,” bill the patient for manual therapy services
   - If the answer to all three questions is “yes,” continue verification questions below

4. Which manual therapy services are authorized?
   Service 1: __________________________ CPT Code: __________________________ Any restrictions/limitations (i.e., max units and reimbursement rate allowed)?
   Service 2: __________________________ CPT Code: __________________________ Any restrictions/limitations (i.e., max units and reimbursement rate allowed)?
   Service 3: __________________________ CPT Code: __________________________ Any restrictions/limitations (i.e., max units and reimbursement rate allowed)?
   Service 4: __________________________ CPT Code: __________________________ Any restrictions/limitations (i.e., max units and reimbursement rate allowed)?
   (Add lines as necessary)
5. Requires a Deductible? [ ] Yes [ ] No  Amount: $________
   Deductible Paid? [ ] Yes [ ] No  Amount: $________
   What date will the next deductible be due? _________________
6. Requires a Copayment? [ ] Yes [ ] No  Amount: $________
7. Does co-insurance apply? [ ] Yes [ ] No  Amount:$________
8. Limit on the number of sessions allowed per policy year? [ ] Yes [ ] No  Total per year per incident: _________________
   Number currently available: _________________
9. Limit on total dollar amount spent on services per policy year? [ ] Yes [ ] No  Total $ amount: $________
   Total currently available: $________
10. Authorized treatment dates: _________________ to _________________
11. Authorized number of sessions: _________________
12. Billing requirements:
   a. Preferred billing method: [ ] HCFA 1500 [ ] Other:
   b. Bill must be sent with: [ ] Proof of license/certification
      [ ] Prescription
      [ ] SOAP
      [ ] Progress Report
      [ ] Other (1)
      [ ] Other (2)
   c. Anticipated turnaround time for reimbursement? _________________
13. Are you able to authorize payment? [ ] Yes [ ] No
   Name: __________________________ Authorization #: __________________________ Date: __________________________
Please connect me with someone able to authorize payment

Name:_____________ Title:_____________ Phone:______________

14. Re-authorization
Name:______________________ Title:______________________
Phone:______________________ Fax:_______________________
Re-verification Date:_____________ Time:_______________
Authorized treatment dates:_____________ to _______________
Authorized number of sessions:________________

Is payment authorized?  ☐ Yes → Authorization #: ____  ☐ No
Deductible Paid?  ☐ Yes  ☐ No  Amount: $_______

Total number of sessions [____ ] and total amount spent [$_$ ] as of current date.

*A copy of this form with confirmation letter was sent to the insurance representative on this date: The HCFA-1500 Claim Form

The following section reviews the HCFA-1500 billing form. For a free on-line copy of the electronic form, go to: http://www.dol.gov/esa/regs/compliance/owcp/OWCP-1500.pdf

This form was created by the Health Care Finance Administration (HCFA), which has become the form for insurance reimbursement and receipt for patients. Do not attempt to use your own billing forms; they will not be processed. Each question on the form is explained below.

The form can be filled out on-line and filed electronically to expedite processing. Some insurance companies even require this. However, because you will usually be submitting the HCFA 1500 with other forms and information, which cannot be electronically filed, electronic billing is not usually an option. Some useful notes for submitting this form are:

- Use the following font: “Courier New” size 10 type
- Use forms with preprinted barcodes at the top
- Use one claim form for each appointment
- Use a separate claim form to bill an evaluation (do not combine with other services)
- Confirm you are using the most current CPT codes (especially since HIPAA has meant the loss of grace periods for recently changed or discontinued codes

One expert considers it easier to bill once you have registered a trade name with your state, which will be listed as a “dba” (doing business as), along with your name and qualifications.
### HEALTH INSURANCE CLAIM FORM

#### PATIENT AND INSURED INFORMATION

<table>
<thead>
<tr>
<th>1. INSURED'S I.D. NUMBER</th>
<th>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</th>
<th>3. PATIENT'S BIRTH DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Medicare #)</td>
<td></td>
<td>MM DD YY</td>
</tr>
<tr>
<td>(Medicaid #)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Sponsor's SSN)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(VA File #)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. PATIENT'S ADDRESS (No., Street)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CITY STATE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ZIP CODE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TELEPHONE (Include Area Code)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### PATIENT INFORMATION

<table>
<thead>
<tr>
<th>6. PATIENT RELATIONSHIP TO INSURED</th>
<th>7. INSURED'S ADDRESS (No., Street)</th>
<th>8. PATIENT STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>CITY STATE</td>
<td>Single</td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
<td>Married</td>
</tr>
<tr>
<td>Child</td>
<td>ZIP CODE</td>
<td>Other</td>
</tr>
</tbody>
</table>

#### OTHER INSURED INFORMATION

<table>
<thead>
<tr>
<th>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
<th>10. IS PATIENT'S CONDITION RELATED TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. OTHER INSURED'S POLICY OR GROUP NUMBER</td>
<td>a. EMPLOYMENT? (CURRENT OR PREVIOUS)</td>
</tr>
<tr>
<td>b. OTHER INSURED'S DATE OF BIRTH</td>
<td>b. AUTO ACCIDENT? PLACE (State)</td>
</tr>
<tr>
<td>c. EMPLOYER'S NAME OR SCHOOL NAME</td>
<td>c. OTHER ACCIDENT? YES NO</td>
</tr>
<tr>
<td>d. INSURANCE PLAN NAME OR PROGRAM NAME</td>
<td>d. INSURANCE PLAN NAME OR PROGRAM NAME</td>
</tr>
</tbody>
</table>

#### SIGNATURE

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED DATE

13. INSURED'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 DATE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER


25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

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.)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

SIGNED DATE

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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Instructions for completing the form:

Item 1. For personal injury or Workers' Compensation cases, check "Other" and write the claim number in 1a. For Group health insurance, check the Group Health Plan box and write the patient's social security number or the insurance ID number in space 1a.

Item 1a. Enter the insured's (the policyholder's) insurance ID number. For health insurance, this was used to be the Social Security number, but due to HIPAA, may be another identification number; for Workers Compensation, put the case number; for MVA, use the claim #.

Item 2. Enter the patient's last name, first name, middle initial. If the patient is also the insured, record "same" as the insured's name in item 4. If the insured is someone other than the patient, fill in the insured's name address and phone number.

Item 3. Enter the patient's date of birth (MM/DD/YY) and check appropriate box for patient's sex.

Item 4. If the patient is also the insured, write "same" as the insured's name. This is the policy owner, which in Workers Comp cases would be the employer.

Item 5. Enter the patient's address (street address, city, state, ZIP code; telephone number is optional).

Item 6. Write the patient's relationship to the insured. ("Other" is typically reserved for the Employer in a Worker Comp case.)

Item 7. The insured's address; if the patient is the policy holder, write "same." It could be the employer of the patient, the individual with primary insurance covering the accident, or someone else.

Item 8. Write patient marital and employment status.

Item 9. Write any second party coverage that will contribute money to the claim. It should be the policyholder's information. In some cases the secondary insurance will cover a deductible or copayment amount as well as any additional medical costs after the primary insurance coverage is paid out. It could be the patient's car or health insurance.

Item 10. Write what the patient's condition is caused by.

Item 11. The insured's policy number (could also be the group plan number, claim number, or social security number). It is usually the number that specifies the insured's type of insurance plan.

Item 11a. Insured's (policyholder's ) date of birth and sex.

Item 11b. Write the employer's name or school name if the institution is providing the insurance plan. Leave blank for personal injury cases unless the injury occurred at work.

Item 11c. The Insurance Plan Name or the Program name.

Item 11d. If there is another health benefit plan, check yes and complete section nine.

Item 12. The signature of the patient or authorized representative is required to authorize release of the medical information necessary to process the claim, and requests payment. However, if the individual has signed a release as part of the billing information form, you can note, "signature on file", instead of having the patient sign every claim form. The date noted with the signature should be the date the patient signed that form.

Item 13. This signature authorizes the insurance company to pay the health care provider directly. If a signature is on file, note "signature on file," and the date it was signed.

Item 14. The date of accident, illness, or injury.

Item 15. Leave blank.

Item 16. Leave blank.

Item 17. Leave blank.

Item 17a. Write the ID number of the referring physician. Do not leave blank!

Item 18. Leave blank.

Item 19. Leave blank.

Item 20. Leave blank.

Item 21. Enter the diagnosis(es) of the condition(s) being treated using current ICD codes. This must be what was diagnosed by the doctor on the prescription or referral. Each diagnosis must be within your scope of practice. Enter codes in priority order (primary, secondary condition). Coding structure must follow the International Classification of Disease, 9th Edition, Clinical Modification or the latest revision published. A brief narrative may also be entered but not substituted for the ICD code. It is best to limit this section (each form) to no more than four diagnosis codes.

Item 22. Leave blank.

Item 23. Leave blank or use the referral number from the health care organization.

Item 24. Column A: enter month, day and year (MM/DD/YY) for the date of service. Write the same date in both the "from" and "to" sections.

Column B: enter the correct "place of service" (POS) code (see below). The insurance company may require a specific place of service code, so ask this question of each insurance company. Note that 11 or OF means your office and 12 or HM refers to the patient's home.

Place of Service (POS) Codes for Item 24B
3 School
4 Homeless Shelter
5 Indian Health Service Free-Standing Facility
6 Indian Health Service Provider-Based Facility
7 Tribal 638 Free-Standing Facility
8 Tribal 638 Provider-Based Facility
11 Office
12 Patient Home
15 Mobile Unit
20 Urgent Care
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room – Hospital
24 Ambulatory Surgical Center
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance – Land
42 Ambulance – Air or Water
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center (CMHC)
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
60 Mass Immunization Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Place of Service

These letter codes are also used:

AC: ambulatory surgical center
ER: Emergency Room
HM: Patient' Home
HS: Hospice
A massage therapist must have one of the following to begin treatment:

- A prescription (including the plan of treatment, diagnosis or diagnoses, and the number of treatments that should be provided)
- A written referral
- A statement of medical necessity signed by the doctor

Insurers will pay only four therapeutic procedure units for one day of service, if two body areas are diagnosed for treatment. Further, a health care provider may not provide the same physical medicine procedures as another provider on the same date of service (concurrent care). The best way to avoid potential double-billing or billing over the maximum number of treatments allowed is to provide your services on a day on other services are provided.

On each date of service, only bill a maximum of 2 units of therapeutic procedures per body area, and a maximum total of only four units for one date. In billing the maximum of four, you would be treating more than one diagnosed body area. [In the world of insurance reimbursement, the body has three main areas: the upper extremities; the torso (which includes the head and neck), and the lower extremities.] Even if diagnoses for all three body areas exist, you are limited to two units of therapeutic procedures per body area (meaning no more than four per date of service). Additionally, even when there are a number of diagnoses for one body area, a total of only two therapeutic procedure units per one date of service can be used (not two per each diagnosis).

Each therapeutic procedure unit is a 15-minute segment. Because you are limited to either 2 therapeutic procedures (for one diagnosed body area) or 4 therapeutic procedures (for two diagnosed body areas), the maximum treatment time on any one day of service is limited from 30 minutes to one hour.

Never list more than one unit per line item in area #24 G (days or units) on the HCFA form. If you use a combination of therapeutic procedures, break them down into 1-unit increments to fill out the form. It is acceptable to charge for more than one therapeutic procedure on one day of service. Treatments end when maximum medical improvement is reached. You will not be paid for services or treatments that exceed that date of service (DOS), even if you have not reached the maximum allowable treatments for that day.

Here is a list of helpful hints for submitting the bill (HCFA-1500) and attachments:

- Submit HCFA forms in large envelopes so the forms inside will not be folded. Automatic reading and processing by machines is made more difficult by folded or creased forms.
- Submit the original HCFA-1500 form; not a photocopy.
- Do not staple anything to the HCFA-1500 form. Simply fold attachments in with the bill.
- Bill only one date of service on each claim form. Sending bills in regularly and frequently (rather than billing multiple dates of service for the same patient at one time) will facilitate faster payment.
diamond Use appropriate codes. See the following sections on CPT and ICD codes. Avoid using more than two CPT codes and two ICD codes on each HCFA-1500 form.

diamond Keep bills under a few hundred dollars, if possible. Smaller amounts tend to be paid automatically, while large or less frequent billing tends to undergo greater scrutiny or require review.

diamond On each date of service, only bill a maximum of 2 units of therapeutic procedures per body area, and a maximum total of only four units for one date. (see concurrent care info)

diamond Send claims and all other insurance-related forms by Certified Mail with Return Receipt Requested. You can send a number of claims in one envelope, but it is best to avoid sending more than one claim for each patient. It is well worth the extra postage.

diamond Most states require submission of claims within 30 days of the appointment. Refer to the insurance commissioner's office in your state's capital to find out how long you have to submit bills to insurance companies and how long insurance companies have to pay after receipt of a claim. Stay within these timeframes and call the insurance company to check status soon after filing. In Florida, healthcare providers are allowed to extend the period of time to greater than 30 days if they provide a Notice of Initiation of Treatment to the insurance company within 20 days after the first treatment.

diamond Keep a copy of all the materials sent to the insurance company, especially the HCFA-1500.

HIPAA ended a grace period for the use of outdated codes. Verify codes before you send in the claim. The referring or prescribing doctor typically has a person dedicated to billing or a paralegal in the office who can answer most questions. Verify the prescribed treatment plan and insurance coverage with this individual. Verify the time allowed for treatment and number of treatments allowed in total. Verify everything.

ICD and CPT codes

CPT stands for Current Procedural Techniques. These and ICD codes (International Classification of Disease) are developed by the American Medical Association and updated about once every 10 years. They are used in physician's prescriptions and medical necessity forms, the documents you will use to guide your treatment plan. Most of the codes used by massage therapists are physical therapy codes, as massage therapists do not yet have their own category of codes. You must be properly trained and licensed for whatever services you offer (see scope of practice, below).

The following codes are commonly used by massage therapists, but you should realize that there is some controversy regarding many codes. Insurance companies may provide codes that you can not legally bill, and every agency or institution may have its own ideas about which codes are appropriate. For example, some companies consider 97214 "relaxation massage" and will not accept it as a treatment code; others have no problem with it. Some companies will not allow billing for both 97214 and 97140 in the same session.

97122: therapeutic procedure, one or more regions, 15 minute segment each [may include neuromuscular reeducation, balance kinesthetic sense, posture, coordination, Propropriocceptive Neuromuscular Facilitation (PNF), etc.]

97124: therapeutic procedure, one or more regions, 15 minute segment each (may include effleurage, petrissage, and/or tapotement). There is some controversy over this code.

97140: manual therapy techniques, one or more regions, 15 minute segment each (may include manipulation, manual lymphatic drainage, mobilization or manual traction, etc.)

Another common treatment code used by massage therapists is 97010 (hot/cold packs).

ICD codes are diagnostic codes that must be furnished by a physician. As massage therapists are not able or allowed to diagnose conditions, it is critically important to have a referral/prescription or letter of medical necessity from the primary care physician. While some insurance companies may say this is unnecessary, this process protects you in situations where the case goes to court, arbitration, or mediation.

Insurance is legally liable for payment of massage treatments if a doctor has determined that massage therapy is medically necessary. The doctor must include a treatment plan and signed statement that the medical treatment is medically necessary. The treatment plan comes directly from the prescription, using the specific modalities instructed by the doctor. You provide the therapy in your role as an ancillary provider, fulfilling the treatment prescription according to the doctor's instructions. Before you begin any treatment plan, you must have the precise code for the specific condition or disease.

Scope of practice

Scope of practice refers to your area of competence, usually obtained through formal study, training, and/or professional experience, and one for which you've received certification or other proof of qualification. Unlike other standardized training programs or fields of study, schools of professional massage therapy, and state requirements, vary significantly in number of necessary hours of study and curriculum. Some schools provide substantial training in specialized procedures, such as lymphatic-drainage techniques or hydrotherapy, while others may only touch upon these subjects, if they are discussed at all.

Your scope of practice is defined, in part, by local licensing restrictions, which are sometimes very general. Within this legal parameter, massage therapists have some latitude in determining what modalities will constitute their practice. Misrepresenting your educational achievements, credentials, or abilities is a serious breach of responsibility that endangers client safety and reflects poorly on the profession as a whole. If a subject is outside your area of expertise, don’t hesitate to say so, and direct the client to appropriate informational resources or professional services.

Choosing to provide services for which you are not appropriately trained or competent is a dangerous personal decision that undermines the profession and may carry weighty legal implications. Your personal level of discretion and ethical standards will largely determine the manner in which you advertise your services, describe your education and professional experience, and list credentials. You will have to decide for yourself if you can rightfully claim substantive experience in a discipline for which you've attended a three-hour workshop or watched a series of instructional videos, or when you can properly call yourself an expert in one modality or another.

In insurance reimbursement, your scope of practice is circumscribed by three points: your qualifications, the doctor's diagnosis, and the doctor-prescribed treatments you carry out. Massage therapists are only able to legally provide certain services or treatments, regardless of a doctor's diagnosis or treatment plan. Scope of practice has been a volatile issue in the fields of massage therapy and medical massage therapy for a number of reasons. In non-licensing states, competency
and scope of practice is defined solely by the practicing individual's claims.

In states that license massage, a governmental regulatory board establishes scope of practice for each state. Many of these rules are subject to interpretation. The ambiguity of these laws encourages professions to self-govern to a large extent. However, in massage therapy, this has worked to undermine the field's professional status. While the body of regulation for massage is largely undeveloped, massage therapists are required to correctly navigate these laws and protocols.

For example, most licensing states allow the use of cold or hot packs, but do not allow any mechanical devises beyond this modality. In Florida, a massage therapist can also use electrical stimulation and ultrasound, but only if the therapist is competent in these areas. Insurance companies, in guarding themselves from fraudulent claims submitted by unqualified individuals, will examine your billings with a fine-tooth comb, and are ever-vigilant in spotting problems like concurrent care billing, errors in coding, diagnosis, and work beyond the massage therapist's scope of practice.

As a massage therapist, you are required to treat only and exactly what has been diagnosed by the doctor. In some cases, you may come across a diagnosis that does not specify the treatment of soft or superficial tissue. While many codes may be appropriate and safe diagnostic conditions, the insurance company must interpret your work based on what is written in the documents you submit. You may manipulate soft tissue only for the purpose of affecting the soft tissue around and encapsulated by the joint. Any time you submit diagnosis or a treatment plan dealing with a bone or joint, you are practicing outside your scope of practice, and you will not be paid.

Making suggestions or recommendations regarding basic stretching or exercise, for example, is not permitted. Doing so is prescribing treatment. While are many different activities and exercises that complement massage therapy, they should not be a part of any treatment prescribed and paid for by insurance. As an ancillary provider, you have no latitude in suggesting treatments for the doctor's patient. Prescriptions must be followed exactly. This means the exact type of treatment, and number of sessions, specified by the doctor. You will only be paid for what the doctor has prescribed. Again, there is no latitude for determining your own treatment approach. Needless to say, this is the easiest way to anger and alienate the medical community. Always discuss any suggestions with the doctor before mentioning them to the injured individual. There may be good reasons they have not been recommended by the doctor in the first place.

Doctors may not hesitate to complain to the board of massage in your state if they feel you are practicing medicine without a license, which can result in disciplinary action or revocation of your license. For example, most massage therapists recommend drinking extra water, especially after certain types of massage. However, if the injured individual is taking a diuretic, it may be contraindicated. Similarly, recommending gentle stretches to someone recently injured in an auto accident is a dangerous mistake.

**Documentation**

Computer-based documentation is becoming increasingly common. Many health care facilities use templates and fill-in forms, both paper and computer-based, to save time in documenting initial evaluations, progress notes, reevaluations, discharge summaries, and physician progress updates. Examples of a daily health report form, and SOAP notes form have been included, but you will want to develop your own documentation forms appropriate to your work and scope of practice.

While fill-in forms and templates can facilitate treatment and improve consistency, it is important that practitioners not let the form "dictate" the session. Because forms can promote incomplete documentation, health care providers must be sure that forms contain all necessary information and have areas where you are able to add narrative comments, allowing you to describe aspects of the patient's care that are not part of the standard forms. The instructions below should give you a general idea of what information to include in your documentation and where.

**Short history of medical documentation**

Documentation in health care practices takes a variety of formats depending on the type of patients being treated, practice setting, state laws and practice acts, and reimbursement requirements. Different documentation formats include narrative reports, problem-oriented medical records (POMR), SOAP, and functional outcomes reporting. A brief discussion of each of these formats follows.

Narrative documentation describes the practitioner's encounter with the patient in a paragraph format. There may or may not be headings identifying important information. Narrative notes are useful when you just need to describe the details of a situation in the most straightforward form. Narrative documentation, however, lacks structure, which can mean important details may be left out. Additionally, there is no standardized format for narrative; each practitioner has a different style, which makes interpretation difficult.

For these reasons, more structured documentation formats were developed. Problem-oriented medical records (POMR) were introduced by Lawrence Weed for use by medical students documenting patients' problems. The POMR system is centered around the identification and resolution of the patient's problems. Although the problem-based approach is also intended to lead to a diagnosis, the problem based approach prevents the clinician from "jumping to a diagnosis" with tunnel vision and potentially overlooking important aspects of the patients disease(s).

To make the presentation better organized and easier to follow, the first page of the POMR is a list of the patient's problems, which serves as a "Table of Contents" for the rest of the medical record. All the entries that follow, called progress notes, are organized according to the list in the Table of Contents. In each entry, the physician discusses the following dimensions of each one of the problems:

- Subjective Data: symptomatic data from the patient.
- Objective Data: test results and quantifiable assessments
- Impression (Imp.): The practitioner's impression of the patient's particular condition or problem.
- Treatment and Therapy (Rx): That particular session's treatment or therapy for that specific problem.
- Immediate Plans (Plan): Treatment plan related to that problem

The POMR is both comprehensive a problem-specific, and it is organized in such a way as to allow a physician to go directly to a specific problem, without paging through lengthy narrative. This brevity typically results in improved communication among care providers. The POMR also provides a chronological sequence of interventions for each particular problem.

The POMR, has been criticized however, for separating or fragmenting patients into their component problems, which may encourage the practitioner to lose the "big picture" of the whole patient. There may be cases in which one health care provider or practitioner working with one area of the body might not be aware
of a problem in another area if he or she has not read every separate chart entry. POMR charting, for patients with more numerous conditions or complaints, can become exceedingly complicated. An individual managing multiple problems would be responsible for multiple chart entries each visit, which could become very time-consuming.

SOAP is an acronym for Subjective, Objective, Assessment, and Plan. SOAP evolved from the POMR documentation format developed by Weed. As with the POMR, "S," or subjective, should include anything the patient tells you pertaining to his or her injuries or problems. Subjective information can also be any information provided by the patient's family or caregivers. The "O," or objective, section should include relevant tests and measurements performed, the patient's functional status, and physical therapy interventions performed for that day of service. Unlike the POMR, in the SOAP format, the physical therapy interventions are written in the objective portion of the note. The interpretation, or impression, has been designated "A," for assessment. In SOAP format, the "P" stands for plan.

The purpose of a SOAP chart is to document the patient's current condition, the therapist's findings and treatments, changes resulting from the treatment, guidelines for future treatments, and the patient's homework. SOAP charting is a popular format for documenting treatment sessions in the health care field, and is widely accepted by a variety of medical and rehabilitation professionals.

No longer associated with the POMR, SOAP charting has become a stand-alone format for documentation, and may or may not be preceded by a problem ("Pr") section. When it does, the "Pr" section contains information pertaining to the medical diagnosis and/or referral information.

In recent years, there has been increasing focus on functional outcomes reporting (FOR), in which SOAP notes demonstrate the effect of impairments on functional limitations. According to Documentation Basics: A Guide for the Physical Therapist Assistant, by Mia Erickson EdD, MS, PT, ATC; Becky McKnight MS, PT: "Even though SOAP notes provide a consistent and concise format for documenting the patient's subjective remarks, objective exam findings, the provider's overall impression, and the plan of care, the documentation procedure has been scrutinized recently. Several reasons for this scrutiny exist. First, objective findings are often written in terms of impairments, such as range of motion, strength, balance, etc. Furthermore, links between improvements in the patient's impairments and improved functional capabilities are usually implied, rather than described in detail. This often results in documentation centered around the patient's complaints and impairments, rather than documentation that focuses on progress and improving function. In addition, SOAP notes usually don't show how the interventions are contributing to functional improvements." 8

Functional outcomes reporting (FOR) is described as a type of documentation that focuses on the ability to perform meaningful functional activities, as opposed to focusing on isolated musculoskeletal, neuromuscular, cardiopulmonary, or integumentary dysfunction or impairment. FOR is considered advantageous for establishing a link between the patient's impairments and his or her ability to perform functional tasks. To accommodate the movement toward FOR charting, some practitioners suggest combining FOR with the SOAP format, making the following additions to SOAP notes:

In the objective (O) Section, the practitioner should clearly describe the patient's functional status, including functional activities that are required by that patient.

In the assessment (A) Section, list only those impairments or conditions being addressed with treatment or therapy. Describe how improvement in impairments will lead to improvement in functional limitations. Provide any complicating factors, and write patient objectives using functional terminology.

This section will review using SOAP as the basic structure for your notes, with an emphasis on FOR: that is, documenting the patient's functional status; specifically linking impairments, functional limitations, and interventions; and tying interventions with improvement.

**SOAP notes**

Medical documentation of patient complaint(s) and treatment must be consistent, concise, and comprehensive. Many medical offices use the SOAP note format to standardize medical evaluation entries made in clinical records. The acronym SOAP stands for SUBJECTIVE, OBJECTIVE, ASSESSMENT, and PLAN. The four parts of a SOAP note are outlined below.

The SOAP note is a brief report in the patient's chart, completed the day of the appointment when the patient is seen. It is different from a comprehensive progress note which may accompany a diagnosis. The SOAP note should briefly express the following:

- Date and purpose of the visit.
- The patient's symptoms and complaints.
- The current physical exam.
- New lab data and results of studies, reports, assessments.
- The current formulation and plan for the patient.

Charting is a critical way for all health care workers to coordinate their care; to speak in the same clinical language, organize and record information, and chart progress together. SOAP notes also act as legal documents, for potential use in litigation of personal injury cases, proof of improvement or restoration to pre-injury status, and completion of functional outcomes.

As we have noted, there are many different "styles" in which medical records are written. A goal of any practice should be to have a uniform record keeping system that is consistently used by all members of the practice. A medical record should "speak for itself". One should be able to read a well written medical record and without ever having seen the patient, be able to gain a comprehensive understanding of the patient’s medical care.

**General principles of Soap charting**

When you are taking notes related to SOAP charting, write only pertinent verifiable details and avoid ambiguous or extraneous information. Record information that addresses a concern or facilitates its solution. Brevity is important but do not leave out important details. Ask questions to confirm or rule out specific conditions or injuries. Be factual and concise. Write with objectivity; avoid opinion or speculation. It is often useful to quote a patient directly, noting his/her words with the use of quotation marks.

It is also important to become well acquainted with common abbreviations. Many useful learning materials provide standard abbreviations used in most health care facilities. You will likely develop your own descriptions and abbreviations to suit your specific needs. Too much shorthand can be detrimental however, because others must be able to interpret everything you have written on the chart. Insurance company personnel will be depending on your notes.
If you include abbreviations that are unusual, add a key with a list of words you have abbreviated and what they stand for.

It is critical that you quantify, or measure, detailed information about the patient over a period of time, to document his or her injury/illness and rehabilitation. Insurance companies will be determining need of continued care from your descriptions. Handwriting is important, and payment can be denied based on illegibility of notes. Sign or initial, and date, every chart entry. It is best not to use nicknames as these notes are legal documents. Your credentials as a health care provider are also a necessary part of the notes. Individuals in training, students, or apprentices must also have a supervising practitioner sign chart notes.

**Soap charting with functional outcomes**

According to Diana L. Thompson, who has written an authoritative account of SOAP note requirements for the purposes of massage therapy insurance reimbursement:

“The current trend in medical documentation is functional outcomes reporting: setting goals and designing treatments to improve function. This style of documentation addresses the patient’s ability to participate in everyday activities. 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.”

No matter what kind of soap charting you do, you must address functional outcomes; that means your notes must describe your patient’s ability to function in daily activities, both work and non-work. Your notes will have to meet requirements set by insurance companies, your immediate company or employer, the other health care professionals caring for the patient. Together you will establish objectives that enhance function, returning the patient’s body to pre-incident status.

Functional outcomes should be written in terms of desired objectives that are established by the patient with help from the health care professionals. Patients and health care providers establish “goals,” the activities the patient is trying to accomplish, with some difficulty. Each goal may be defined as one or more functional outcomes.

Discuss the patient’s needs, and determine, with him or her, some primary requirements. Keep these rules of thumb in mind: The information you write should be “SMART”:

- **S**pecific to a particular action
- **M**easurable: can be broken into subunits to show changes and improvements
- **A**ttainable or **A**chievable: can be realistically accomplished by patient
- **R**elevant: necessary to the patient’s daily functioning
- **T**imely: A time-related activity

Functional outcomes can involve work or leisure activities, but they should be bounded, with a specific function; in general, the more specific the better. Does standing to complete a certain activity wear the patient down? Is pushing a vacuum cleaner or a lawn mower impossible, putting on socks and shoes difficult? Sitting in one position at a desk, typing, painful? Break down the activity into basic movements and determine what specific parts of these actions cause pain. Activities intrinsic to childcare, like lifting an infant; self-care, putting on one’s shoes, reaching, sitting—all are necessary activities in caring for oneself and others. In cases of on-the-job injury, your primary objective is work-related activities that can be described in terms of functional outcomes.

Once the specific relevant activity is chosen, it must be defined in measurable terms—consider how progress toward the goal will be quantified. This can be done in a number of ways. For example, the activity can be performed for a certain duration-length of time, or number of repetitions, which can be increased over time. Record the patients desired status at the end or outcome of the activity: pain free, no fatigue, with unlimited motion, etc…

Provide a time frame for completing the activity with the desired outcome status: First, establish long-term goals, if they are appropriate; those which may not be reached for a period of months. Then develop a number of moderately timed goals, attainable in a period of one to two months. Short term goals may simply be the long term objectives cut up into measurable or manageable increments.

Goals should never seem or be overwhelming; they must be attainable and realistic, and sufficiently within reach to avoid needlessly frustrating the patient. Carefully evaluate the degree or severity of injury, and the patient’s general health status, to determine if the goal is attainable in the allotted time-frame. It may be necessary over the course of treatment to readjust the time frame to approximate a specific patient’s healing abilities and speed.

Be realistic about your patient’s capabilities and take understand the extent of injury fully; also be attuned to your patient’s degree of discomfort or pain during the activity. While pain reduction is important, it is not a functional outcome. If reducing or being free of pain is a part of the objective, discuss activities that are not pain free and break the activity into smaller more manageable, less painful movements.

Begin with a description of the injury status.

Ask the patient:

- What is a necessary (work-related) activity in which you are currently limited?

Then:

- Specify the active details of that activity.
- Break it down into useful units according to time
- Prioritize functional activities in order of importance
- Describe measurable results; standing for how long a period, lifting a specific amount of weight, with a specific outcome status—being able to do complete the activity without pain medication or exhausting oneself, for example

**Subjective**

The initial portion of the SOAP note format consists of subjective observations. These are symptoms given verbally to medical personnel by the patient or by a significant other individual, such as a family member or friend. These subjective observations include the patient’s descriptions of pain or discomfort, the presence of nausea or dizziness, and any other descriptions of dysfunction, discomfort, or illness, or weakness.

In documenting the symptoms, conditions, or concerns of the patient, consider this guiding question: Why is the patient seeking treatment? Is it for an injury or condition, troubling symptoms, health maintenance issues, etc? While most of this information comes from patient; other documentation, such as the prescription, may also provide test results or the diagnosis.

As discussed earlier, SOAP charts commonly include a “P” section (PSOAP), in which P stands for “Problems” (like in POMR) that
may be contributed by individuals than the patient. Note all health concerns, specifically those essential to daily function, then describe any actions that exacerbate or aggravate the symptoms, as well as those actions that relieve or reduce the symptoms.

To assist you in getting a full list of symptoms from the patient, you may want to review intake forms for pertinent background information: Record facts about the patient’s general condition and normal function, as well as any fatigue, pain, or stress they are experiencing. The progress report form included in this chapter helps collect this information. You may want to specifically asking about the following conditions:

- Pain/discomfort
- Stiffness
- Numbness/tingling
- Swelling
- Weakness
- Paralysis

Have patients mark the diagram in the appropriate area to show the location of each symptom. The area of pain typically diminishes in size as it heals, so is a useful way to show rehabilitative progress. Once the size and affected area of symptoms are identified, have the patient describe the degree and duration of pain using a scale similar to the one provided as an example on the progress report.

At minimum, you should record the period of time the pain lasts, its frequency, and when or in what situations it occurs or recurs.

Assessing pain

Take a careful pain history as part of a pain assessment. Include the following:

- What makes the pain better? What do you do to get relief? What helps you?
- What makes the pain worse? What brings it on? What aggravates it?
- Quality of pain: What does the pain feel like? What words would you use to describe it?
- Radiation: Where is the pain? Does the pain go anywhere else? Does it spread? Can you put one finger in the center of the pain?
- Severity: How bad is the pain? At its worst? At its best?
- Temporal course: When did the pain start? How often does it occur? How often the symptom occur. Terms like “rarely” or “occasionally”, are much less useful than specific descriptions such as “every hour,” or “four times a day.”
- Treatment: What have you tried to relieve the pain? How effective was it? Why did you stop it?

In the description of pain, use of a rating scale can be very helpful. There are many different rating schemes. Many use a scale of 0 to 5 or 0 to 10. Pain free is rated at 0, with each higher number associated with a specific amount of pain. Other rating scales use words, like “light,” “moderate” or severe.

The following method is probably the most familiar, “On a scale of zero to ten, where zero means no pain and ten equals the worst possible pain, what is your current pain level?”

Numerical scales:

```
| No Pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | Worst Pain |
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Common mistakes include the interviewer saying or writing, “On a scale from ONE to ten” or “and ten equals the worst pain THAT YOU EVER HAD”. In the first example, the error is stating that one is the low end of the scale. As the second example shows, it is important not to put the highest end of the scale in terms of past experience.

The numeric rating scale may be categorized into no pain (0), mild pain (1-3), moderate pain (4-6), and severe pain, (7-10).

The purpose of the scale is two-fold: (1) to understand the patient’s perspective, and (2) even more important, to reassess the effects of treatment. By using the same rating system over time, you will be able to chart the effectiveness of treatment.

Remember to take a careful history that includes prior and present medications, and note the onset of peak analgesic effects, duration of action, level of pain relief (0 to 10 scale), and side effects. It is VERY important to include the amounts and time-frame of any medications, to get a full picture of the patient’s progress. In describing the duration and frequency of pain, record the period of time the symptom lasts, using seconds, minutes, hours, etc; and how often the symptom occur. Terms like “rarely” or “occasionally”, are much less useful than specific descriptions such as “every hour,” or “four times a day.”

It is also important to describe the onset of pain, which may include the setting of the injury and contributing factors. Because a clear description of the biological basis or mechanisms of injury and compensating symptoms are important to justifying or substantiating specific treatment options, you will want to include this information on soap charts. In the case of an accident, the date and cause of injury should be included. In many cases this date is used to identify the claim.

Intake forms should have detailed information regarding the mechanics of injury and onset of symptoms. In the case of an automobile accident, for example, the physical biomechanics and all conditions of the accident should be documented. In case of an accident, the discussion of the injury should include body positions, any twisting of the body, any weight involved and levels (moved 50 lb box to shelf five feet off the ground). In cases of falls, note the body part or parts that hit a surface or surfaces, and describe the type of surface and progression of impact(s), which will be useful to develop a treatment plan.

If symptoms of a condition or illness predating the accident were aggravated by an accident, the description should include this information and an explanation that the symptoms concerned are the most recent onset or flare-up. Chart the onset of all symptoms; both those that relate to the accident and those that were preexisting but may have been exacerbated by the injury. While it is difficult to determine an exact date of onset for repetitive motion injuries, try to pin it down to a particular year or season (Winter 98) if not the month (November 98) that it began to hurt. Repetitive motion injuries should also relate daily activities that aggravate the injury.

Describe activities that are limited, explaining how, where, and when function is limited or pain is better. Note how the patient functions in daily activities, and if these activities are associated with specific symptoms. Describe the pre-incident level of function, and the current level, including the symptoms associated with doing the action. If it is a limitation, describe how the debility affects normal functions at home and work. Explain how each of these functions are linked with the specific activities the patient must do daily: sitting, standing, lifting, sleeping, etc… Discuss its relevance in the patient’s life.

Consider the activities the patient is no longer able to do. Describe the activity and note the amount of time or duration of a specific activity accomplished before you see signs of fatigue, stress, or pain.
For workers compensation benefits, it is especially important to include work-related activities. In all cases, however, use actions that act as representative samples of leisure as well as work activities, but also include a balanced representation of the patient’s usual activities.

Document exactly how long the patient can endure the activity before symptoms become pronounced; you will be able to compare previous sessions to this session to assess improvement in the patient’s functioning and ability to get things done, related to both work and leisure activities. As a patient’s activity level improves without painful symptoms, some patients may be tempted to do more than they should. Caution patients not to set themselves back by taking on too much as they are still healing.

Note actions that ameliorate or facilitate relief, such as sitting or standing with a different posture, changing positions frequently, stretches, manual therapies and hydrotherapy-anything that may relieve symptoms. Help patients learn how to ease their own symptoms. Remind them to take breaks, as needed. Reviewing and confirming what aggravates or relieves the injury allows the patient to facilitate his/her healing and control pain, to some extent, or at least avoid exacerbating the injury or symptoms. Note the patient’s progress as he/she achieves a fuller range of motion, reduced pain, etc…

In short, the subjective section includes:
- Patient’s complaints
- Date of onset of symptoms
- Cause of symptoms
- Duration of symptoms
- What aggravates symptoms
- What relieves symptoms
- Patient’s consideration of treatment

Objective

The next part of the format is the objective observation. These objective observations include symptoms that health care providers can actually see, hear, touch, feel, or smell. Included in objective observations are measurements such as temperature, pulse, respiration, skin color, swelling, and the results of tests. In short, objective findings include data from:
- Visual examination (patient’s functional status, i.e., gait, transfers, bed mobility, stairs, etc…)
- Interventions (including communication, discussion or coordination of care with other individuals involved with the patient)
- Procedural interventions (including physical agents, modality, therapeutic exercise or activity, equipment used, repetitions, duration, frequency, target tissues/area, position, dosage, and/or time)
- Patient-related instruction (training or education provided to the patient and/or family)
- Measurable data from relevant tests and measures [e.g. range of movement (ROM) strength, balance, sensation, etc.]

Work within your scope of practice. Do not run diagnostic tests if you do not have a diagnostic license. Assessment testing varies enormously among different branches of manual therapy. Most manual therapists use a visual exam, while others include motion testing and palpatory findings in their work. The testing process should be consistent, measured both before and after treatment and listing all findings. Do not use diagnostic terminology unless the referring health care provider indicated a diagnosis.

Perform assessments consistently across sessions so you are comparing exactly the same thing each visit. Make sure the patient is in the same exact position; sitting, for example, each time, as you check range of motion. Take measurements carefully, and use the appropriate terminology. Note a variety of findings, including any inflammation, spasms, trigger points, or joint dysfunction. For all information, compare bilaterally, (initially, with a vision test), and address the patient’s deviation from normal function or use. Ask the patient to compare him/herself to the period before incident or injury.

In a visual examination, for example, note the patients’ ease of motion, posture, appearance, any signs of trauma, swelling, cuts and scrapes, or any other visual data. Document the position of the patient during the assessment (seated, standing, etc.); the angle of observation, the action or activity, and any radiating or referred pain that results. Note restricted or abnormal movement or gait, difficulty breathing or shortness of breath in any situation. Measure deviation from normal posture, any irregularities in the spine, or rotations. Describe the quality of movement, the ease or difficulty, the duration of the movement, at what point the patient feels fatigue, symptoms or sensations associated with the movement, and degree of expression.

In a palpatory examination, note any abnormalities in muscle tone, pain, scar tissue, or inflammation. Examine the patient for adhesions, hypertonicity, muscle spasms, and trigger points. Rate the intensity of the finding and emphasize the size and shape of the area affected as closely as possible. Many practitioners use human figure drawings, marking or drawing in areas of concern. First mark the diagrams to indicate symptoms or conditions, describe them briefly on the picture, then write in more detail in the narrative entry under “O” for Objective. Identify the location, the type of trigger, and referred or radiating pain, if any.

In range of motion (ROM) testing, also, you may be marking a diagram of a human body, showing greater range of movement and decreased pain as the individual improves. ROM is used to assess inflammation and degree of severity in joint trauma, strains, and sprains. ROM test results are used to describe a particular level of dysfunction and assess progress, as well as identify a specific condition or weakness. In conducting ROM testing, identify the position of the patient (standing, seated, prone, etc…); the type of test (active, active assisted, passive, etc…); the joint involved; and the action (flexion, extension, etc…). Identify and quantify any deviation from normal (using the appropriate term), and the cause of the limitation; and identify and characterize the quality of movement (smooth, segmented, spastic…) and accompanying amount of pain or discomfort.

It is common in physical therapy to assess patient improvement based on increases in range of joint motion and muscle strength. Limitations of joint motion must be noted so that the patient or examiner does not try to move the joint past the limitation. Both motions are compared to the accepted ROM for that joint, and any limitation in range is noted.

Other types of testing

Many useful pain and disability questionnaires provide highly accurate and detailed charting of pain. The following table includes some of the most common pain and disability questionnaires currently in use:
Types of Pain and Disability Questionnaires
Table adapted from
http://www.clinicalinfometrics.northwester.edu/archive/Tab
percent208 percent20Pain percent20Measures.pdg

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Type of pain</th>
<th>Scale</th>
<th># of items</th>
<th>Administered by</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual Analog Pain Rating Scale (Various authors, 1974)</td>
<td>General Pain</td>
<td>ratio</td>
<td>1</td>
<td>self</td>
<td>30 sec</td>
</tr>
<tr>
<td>McGill Pain Questionnaire Melzack, (1975)</td>
<td>General Pain</td>
<td>ordinal, interval</td>
<td>20</td>
<td>self</td>
<td>15-20 min</td>
</tr>
<tr>
<td>Medical Outcomes Study Pain Measures (Sherbourne, 1992)</td>
<td>General Pain</td>
<td>ordinal</td>
<td>12</td>
<td>self</td>
<td>varies</td>
</tr>
<tr>
<td>Oswestry Low Back Pain Disability (Fairbank, 1980)</td>
<td>Back Pain</td>
<td>ordinal</td>
<td>60</td>
<td>self</td>
<td>5 min</td>
</tr>
<tr>
<td>Back Pain Classification Scale (Leavitt, 1978)</td>
<td>Back Pain</td>
<td>interval</td>
<td>13</td>
<td>self</td>
<td>5-10 min</td>
</tr>
<tr>
<td>Pain and Distress Scale (Zung, 1983)</td>
<td>Mood/Behavior due to pain</td>
<td>ordinal</td>
<td>20</td>
<td>self</td>
<td>varies</td>
</tr>
<tr>
<td>Pain Perception Profile (Tursky, 1976)</td>
<td>General pain</td>
<td>ratio</td>
<td>37</td>
<td>practitioner</td>
<td>varies</td>
</tr>
<tr>
<td>West Haven-Yale Multi-dimensional Pain Inventory (Kems et. al 1985)</td>
<td>Chronic pain</td>
<td>ordinal</td>
<td>52</td>
<td>self</td>
<td>5 min</td>
</tr>
<tr>
<td>Pain Disability Index (Taitt et. al 1986)</td>
<td>Chronic pain/disability</td>
<td>ordinal</td>
<td>7</td>
<td>self</td>
<td>varies</td>
</tr>
<tr>
<td>Dartmouth Pain Questionnaire (Corson &amp; Schneider, 1984)</td>
<td>General pain</td>
<td>ordinal, interval</td>
<td>5</td>
<td>self</td>
<td>5-20 min</td>
</tr>
</tbody>
</table>

One of the most common tools in the field of Massage Therapy is the revised Vernon-Mior questionnaire, which can be viewed in full at: http://www.chiro.org/LINKS/outcome.shtml#.NDI. Also called the Neck Disability Index (NDI), this questionnaire was developed in 1989 by Howard Vernon. The Index was developed as a modification of the Oswestry Low Back Pain Disability Index with the permission of the original author (J. Fairbank, 1980). Since 1991, a number of studies have confirmed a high level of reliability and validity to the test, with the NDI becoming a standard instrument for measuring self-rated disability due to neck pain that is used by clinicians and researchers alike.

In this assessment, which is scored in the same manner as many other disability rating scales, each of the 10 items is scored from 0 – 5. The maximum score is 50, and the obtained score can be multiplied by 2 to produce a percentage score. Occasionally, a respondent will not complete one question or another. The average of all other items is then added to the completed items.

The original report provided scoring intervals for interpretation, as follows:
0 – 4 = no disability
5 – 14 = mild
15 – 24 = moderate
25 – 34 = severe
above 34 = complete

This means 15-24 out of 50 (the RAW SCORE) is equated with moderate disability.

According to the authors, “the NDI [can] be used at baseline and for every 2 weeks thereafter within the treatment program to measure progress. As noted above, at least a 5-point change is required to be clinically meaningful. Patients often do not score the items as zero, once they are in treatment. In other words, it is common to find that patients will continue to score between 5 – 15 despite having made excellent recovery (i.e., they may be back to work). The practitioner should avoid the trap of “treating till zero”, as this is not supportable based on current evidence.”

The Objective section also documents the length of session, duration of each modality used, and where and how on the body treatments were applied. In most cases, you will use CPT codes for the modalities and list the length of the session using units. Be certain that before you use any CPT codes on your SOAP charts, you know, specifically, which CPT codes (1) fall within your scope of practice, and (2) are reimbursable though the specific insurance plan.

Finally, the “O”( objective) section also documents the patient’s response to specific treatment. Remember to include both positive and negative responses to treatments, note any changes in pre to post treatment findings, and also not what did not change. Note specific techniques and findings and write the most significant points. You will establish priorities for the next session or sessions based on these findings.

Both subjective and objective findings on the SOAP chart should be newly assessed each session.

Assessment
Assessment follows the objective observations, and is usually the diagnosis of the patient’s condition. In some cases the diagnosis may be clear; in other cases, assessment may be ambiguous and include several diagnosis possibilities. Assessment may also include:
- Overall response to treatment
- Changes in the patient’s status
- Progress toward goals
- Justification of need for skilled services
- Explanation of how the treatment is medically necessary
- Summary of impairments, in terms of functional limitations and disabilities
- Effect of intervention on impairments, functional limitations and disabilities
Note the symptoms that the doctor wants addressed through treatment and the functional outcome desired. Practitioners should assess functional ability and limitations in this section, comparing and contrasting previous and current ability, and progress toward accomplishing functional goals. In doing so:

- Prioritize findings from most to least significant.
- Describe current functional limitations
- Describe patient’s previous ability to perform actions
- Explain the part these actions play in the patient’s life, work, and leisure
- Establish and demonstrate long and short-term goals

**Plan**

The last part of the SOAP note is the plan. The plan may include laboratory and/or radiological tests ordered for the patient, medications ordered, treatments performed (e.g., minor surgery procedure), patient referrals (sending patient to a specialist), patient disposition (e.g., hospital, bed rest, short-term, long-term disability, days excused from work, admission to hospital), patient directions, and follow-up directions for the patient.

The plan should establish the timeline, frequency, duration, and at what point the patient should be reevaluated. It should document referral and recommendation for needed testing or services. It should also include self-care-exercises or activities that relieve pain, for example, the use of ice packs or hydrotherapy-and “homework” to strengthen the patient on his/her own.

Describe the homework assignment in such a way that the patient will understand or remember how to do the activity when he/she is at home; it can be anything that will increase the patient’s ability to perform an activity, decrease symptoms, and help attain functional goals. Avoid any activities that cause pain or symptoms to recur, and note activities that make it worse. The patient should note what exercises or activities were successfully or unsuccessfully performed at home, and if they brought relief or no relief. In this way, you can continue the productive homework and discontinue any unhelpful activities.

In summary, the Plan should:

- Plan for the next treatment session
- Plan for patient/family education or training
- Discuss new therapies or exercises
- Discuss frequency of treatment
- Plan for consultation with another discipline
- Plan for reevaluation or discharge
- Plan regarding exercise progression or changes in the plan of care

**Pulling it all together**

Here is an example of a SOAP note with a medical diagnosis in the “Pr” section:

**Date:** 3/3/04

**Pr:** 27 y.o. s/p (L) wrist and ankle fx; Begin gentle wrist and ankle AROM & PROM

**S:** Pt. RTC reporting no adverse effects from tx last visit or from HEP. He stated that his wrist & ankle are moving a little better and the edema in the hand has . He reports that he is able to shower (I) using a plastic chair in the tub and feels like he has improved his ability to dress himself.

**O:** AROM (L) wrist: flexion 30°, extension 30°, UD 15°, RD 20°, supination 45°, pronation 60°; (L) knee: 0-135°; (L) ankle DF-PF 5-45°. Girth: (L) wrist figure 8: 35.5 cm and (L) ankle figure 8: 43 cm. Functional Status: Gait: Ambulates household distances with (B) axillary cx (L) UE platform, PWB 50 percent (L), (I). Transfers: (I) c all transfers Self-care: (I) c showering and dressing. IADLs: Unable to work; Unable to assist wife c child care duties. Tx: gentle AROM and PROM for 30’ to the (L) wrist & forearm for flexion, extension, supination, & pronation. Pt. also performed hand AROM.

**P:** Will continue to have the pt. perform his HEP and RTC on 3/5/04.

Another suggestion for improving the soap format, in worker’s compensation and personal injury cases, where there is a special need for work status information, is to add “ER” to the “SOAP” format. “E” is associated with “employment issues.” Include a record of the patient’s physical and medical ability to work, and information regarding any rehabilitation that the worker may need to undergo. “R” is associated with “restrictions to recovery;” any temporary or permanent physical limitations, and any unrelated condition(s) that may impede recovery.

**SOAP notes**

You will usually be responsible for one of four types of soap notes:

- Initial evaluation and report
- Progress report
- Interim report
- Discharge report

Remember that a finished report is not just SOAP notes. It must be written up formally, with a key for any symbols used that are not commonly understood.

**Initial evaluation and report**

This is the first report of the patient on their first visit. It includes what you have learned from the referring health care provider and the patient regarding the injury and its symptoms. It is the base against which you will note progress. The initial evaluation and report includes a description of the first treatment and your findings. Initial notes should evaluate the whole body, addressing its status in...
full, including compensational posture, and the impact of the injury on quality of life.

The initial evaluation and report establishes a plan for the first series of treatments. List modalities that will be used and their general application, including location, and duration. Note frequency of future sessions, and the date the patient should be reevaluated. The period noted should be long enough to carry out long term treatment goals. Update this plan, as needed, if it becomes inappropriate or is no longer useful. Make any modifications with consideration of the patient’s response to the treatment plan.

Example: Initial evaluation and report
S
The patient complains of [condition] with [frequency, degree, and duration of discomfort or pain] in [body location] with referred or radiating pain to the [body location]. Symptoms are related to a [motor vehicle accident, on-the-job injury, etc.] that occurred on [month day and year]. The patient has had these symptoms for a period of [days, months, years, etc.]. Symptoms are aggravated by [describe activity, posture, etc.]. Patients symptoms are relieved by [activity, posture, therapy, etc.].

O
Visual observation showed [describe abnormal gate or dysfunction, restricted movement, swelling, etc. of the [body location]].
Testing:
ROM: Limited/restricted [rotation, hyperextension, etc.] of the [body region or joint]
Palpatory testing showed [hypertonicity/adhesions/trigger points/spasms] in these muscles:

A
Physician diagnosis is carpal tunnel syndrome 354.0
Functional outcome:
After the last treatment, improvement was noted/not noted
Patients level of pain has [increased/decreased, no change]
After the last treatment [improvement/no improvement] was apparent in
The patient’s level of pain has [increased/decreased, no change]

P
Treatment plan for the patient, as directed by the primary health care provider/referring physician is [massage therapy, myofascial release, hot or cold packs, infrared heat, etc.]. The health care goal is to [reduce inflammation and muscle spasms] which should [reduce discomfort and pain] in the affected areas. The patient will be seen for [number of treatments] and be reevaluated in [number of weeks/months].

Progress report
A progress note sums up the progress that has been made in the patient’s care since the last note. It may also be referred to as continuing care. This is the style of report that is used most often, as it is required for each treatment after the initial report (which is completed once) and the interim report (which may happen rarely, if at all). This SOAP note and its report should focus on the immediate treatment session, and daily goals that are specific to that time period.

Example: Progress report
S
The patient’s condition is [……] as previously reported. In addition, the patient complains of [symptoms, duration and degree of pain or discomfort] in the [location] with referred pain or radiating pain to the [location].

O
At this visit, the patient’s condition is [the same, improved, worse]. There was [no improvement/ improvement] in [……].

P
Today, treatment was [treatment plan]

*Note: in cases, where this session is the last unit and the patient will return to the physician, write: “the patient has been referred back to his/her physician.”

Interim and discharge reports
Interim reports are rare, as they are required for the first treatment under a renewed prescription. The interim report is really the same content as the initial report, except that functional outcome listed under “assessment” should be comprehensive, covering the cumulative effects of all treatments under the previous prescription.

The interim report includes a reevaluation that is as thorough as an initial visit. The patient and practitioner assess progress and develop a new treatment plan, documenting the patient’s status accordingly.

Discharge notes, which are required by some institutions, are a final summary of the patient’s health and recuperation, including subsequent recommendations or referrals related to a treatment plan.

Discharge notes include a summary of treatment with accompanying dates, the patient’s current status and reasons for stopping treatment or care. Write the reasons for discharge in the “plan” section. Also document further steps that should be taken by the patient, ongoing care that is recommended or required, self-care steps, and any referrals.

Progress report
Patient Name:
Date of Injury: _______________ Insurance ID#: __________________

P = pain
S = stiffness
N = numbness/tingling
W = weakness
SW = Swelling

Use the figures to show the location of today’s symptoms. Circle the appropriate area and label with one of the following letters, using the key below:

Pain Scale:
Mark the following scale to show the amount of pain you are feeling today:

No Pain – ---------------------------------- – Unbearable Pain

Activity Scale:
Mark the following scale to show the degree to which you are limited in your daily activities:

Able to do everything – ------------------------ – Unable to do anything

Detailed notes:___________________________________________
_______________________________________________________
_______________________________________________________

SOAP chart
Patient Name:____________________________________________
Date of Injury: ______________ Insurance ID#:________________

S (Subjective) O (Objective)
A (Assessment) P (Plan)
MASSAGE THERAPY
ISSUES IN INSURANCE REIMBURSEMENT

Final Examination Questions

Select the best answer for each question and complete your test
online at www.mymassagece.com.

1. According to the chapter, all the following statements about Medical Massage are true, except:
   a. It is a system of manually applied techniques designed to reduce pain, establish normal tissue tension, create a positive tissue environment and to normalize the movement of the musculoskeletal system.
   b. It is a scientifically based method of manual therapy that seeks a clear understanding of the scientific principles of physiology that affect connective and soft tissue healing and treatment.
   c. It distinguishes between therapeutic massage as a preventive therapy and medical massage, a treatment specifically directed to resolve conditions diagnosed by a physician.
   d. It does not utilize physical therapy codes.

2. Which of the following is not true about Major Medical and indemnity insurance policies?
   a. They are the more traditional health care policies that existed before managed care options were available.
   b. They typically refer to a health insurance plan with a high maximum benefit, and with comprehensive rather than scheduled benefits.
   c. They do not allow the insured individual to use any provider he/she chooses, with specific restrictions regarding physicians and hospitals.
   d. In most states, they have pre-established limits for medical services to specific providers.

3. Which of the following is not true about Managed Care Organizations?
   a. They are also called “fee-for-service”.
   b. They come in a variety of types, including HMO, PPO, EPO, and POS, among others.
   c. They typically require a referring HCP (Health Care Provider) to administer and coordinate care with other health care providers.
   d. The majority of people belong to them.

4. Which of the following statements about HMO’s is not true?
   a. They are health delivery systems that offer comprehensive health coverage for hospital and physician services for a prepaid, fixed fee.
   b. They may contract with or directly employ participating health care providers, including hospitals, physicians, and other health professionals.
   c. This plan typically requires that the insured select a primary care physician (PCP) from within the provider network.
   d. They usually have very high deductibles.

5. Which of the following statements about PPO’s is not true?
   a. They are also known as “open-ended HMO’s”.
   b. They are a group of providers who have joined together, negotiating their rates for treatment with various health plans.
   c. They are similar to the traditional fee-for-service programs, except that they primarily contract with independent providers.
   d. This plan encourages the insured to choose doctors, hospitals, and other providers that participate in the plan by increasing the portion of the bill they pay if the insured stays “in network”.

6. Which of the following is a physician organization established by county or state medical societies?
   a. EPO
   b. POS
   c. FMC
   d. IPA

7. Under this plan, some of the doctor’s income may depend on the plan’s success or efficiency, and participating doctors often share in any losses the plan sustains, or in any profits the plan makes.
   a. EPO
   b. POS
   c. FMC
   d. IPA

8. Federal health insurance resources include this organization, which is part of the U.S. Department of Health and Human Services.
   a. HCFA
   b. MedPay
   c. PIP
   d. Medicare

9. Which of the following is not a type of auto insurance coverage?
   a. MVA
   b. MedPay
   c. BI
   d. UM/UIM

10. Which of the following is not true about motor vehicle accidents?
    a. Millions of people are injured by them each year.
    b. Most are decided according to the law of negligence.
    c. If it occurred while the injured was working, his/her on-the-job injury insurance may be liable for paying medical expenses.
    d. There are three main categories of insurance: first party, second party, and third-party coverage.
11. Which of the following statements is not true about no-fault insurance?
   a. It requires medical healthcare benefits be included in auto insurance policies to cover medical expenses incurred both by individuals driving, riding as passengers, in the policyholder’s car, regardless of fault.
   b. When you have an accident, your auto insurance provider automatically pays for your damages, regardless of fault, up to a specific limit.
   c. It is a civil wrong that is not a crime.
   d. In its strict form, it applies only to states where insurance companies pay “first party” benefits and where there are restrictions on the right to sue.

12. The medical benefits portion of the auto insurance plan in no-fault states is known as which of the following?
   a. PIP or MedPay
   b. Torte liability threshold
   c. MMI
   d. BI

13. Which of the following statements is not true about PIP?
   a. In some states, like Washington and Florida, it is required.
   b. Only one level of PIP coverage is available for purchase.
   c. In some recent cases, some insurance companies have redefined it as limited to the policyholder’s family only.
   d. They usually have a time limit for which services can be billed that varies in each state.

14. All states have had some form of workers’ compensation in effect since ________________.
   a. 1929
   b. 1948
   c. 1972
   d. 1986

15. Which of the following are the two states that widely accept massage therapists as contracted providers in the health care system?
   a. California and Washington
   b. Washington and Florida
   c. Florida and Ohio
   d. Ohio and California

16. Which of the following is not reviewed in the preferred provider assessment or credentialing process?
   a. A passport
   b. A completed application
   c. Proof of licensure
   d. Inspection of work site

17. Which of the following define a “reasonable” fee?
   a. The fee that an individual provider most frequently charges for a specific procedure.
   b. The fee level determined by the administrator of a benefit plan from actual fees submitted for a specific procedure.
   c. The fee charged by a provider for specific services or treatment that has been modified by complications or unusual circumstances.
   d. The fee that was charged in the previous year for the service.

18. The concept of using “usual, customary, and reasonable fees,” (UCR) to determine how much to reimburse patients covered by insurance for specific treatment was introduced by the insurance industry in the early ________________.
   a. 1930's
   b. 1960's
   c. 1980's
   d. 1990's

19. Which of the following statements about UCR fees or rates is not true?
   a. UCR fees are applied consistently throughout the insurance system.
   b. UCR rates may be outdated and may not cover all costs.
   c. UCR fees are influenced by the fees providers charge in various geographic areas and by the population size.
   d. UCR fees widely vary among carriers, and no two carriers use the same UCR definition.

20. The process of preverification includes finding out all the following, except:
   a. What services or treatments are covered by the individual’s policy.
   b. The actual dollar amount of available benefits.
   c. Whether you, as a massage therapist, qualify for payment.
   d. Fee levels set by the Health Insurance Association of American (HIAA).