PROFESSIONAL CONTINUING EDUCATION

Acupuncture Documentation - Practical, Legal, and Ethical Requirements

PRACTICAL

LEGAL

ETHICAL

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Who Requires Documentation

- **State Chiropractic Boards** – licensure requirement
- **Malpractice Insurers** – coverage and defense depend on it
- **Courts** – undocumented care is presumed not provided
- **Professional Standards** – documentation is part of standard of care
- **Corporate Risk Management** – protects providers and the brand

Insurance payers are optional. Documentation is not.

Documentation Is Not About Billing

Documentation is required by **licensure, malpractice risk, and legal defensibility** — not insurance billing.

Even in a 100% cash-based practice:

Providers are licensed clinicians

Providers carry malpractice insurance

Courts and boards presume documentation exists

State Licensing Boards

Failure to document = unprofessional conduct.

The record must be sufficient to permit another practitioner to assume care of the patient and understand the course of treatment.

California

California Code of Regulations, Title 16, Section 1399.453 (Recordkeeping)

- "An acupuncturist shall keep complete and accurate records on each patient who is given acupuncture treatment, including but not limited to, treatments given and progress made as a result of the acupuncture treatments."

Disciplinary actions and investigations the Board generally expects records to demonstrate:

- Patient history and chief complaint
- Examination and assessment findings
- Diagnosis or clinical impression
- Treatment plan
- Acupuncture points and procedures performed
- Progress and response to treatment
- Informed consent when appropriate
- Referrals, consultations, and follow-up recommendations
- Dates of service and practitioner identification/signature

New York Education Law § 8211(1)(b) licensed acupuncturists must maintain patient records that adequately document the care provided. New York also specifically requires that the practitioner advise the patient of the importance of consulting with a physician regarding the patient's condition and maintain a record that the patient received that notice.

- Identify the patient.
- Document the evaluation and findings.
- Support the diagnosis or assessment.
- Describe the treatment rendered.
- Demonstrate the patient's response and progress.
- Provide continuity of care.
- Support billing and professional accountability.

New York

New York regulators would generally expect records to contain:

- Chief complaint
- Relevant history
- Examination findings
- Assessment/diagnosis
- Treatment rendered
- Acupuncture points or procedures utilized Patient response and progress
- Dates of service Practitioner identification/signature
- The required physician consultation attestation form mandated by Education Law § 8211(1)(b)

Florida Administrative Code Rule 64B1-10.001 – Content and Retention of Medical Records.“

Written medical records for each date of service that document the course of treatment and are:

- Legible
- In English
- Consistent with acupuncture standards of care.

Florida

1. Patient Medical History
   - Current Medical diagnoses
   - Medications
   - Allergies
   - Surgeries
   - Implants or prostheses
   - Other medical treatments being received
2. Acupuncture Diagnostic Impressions
   - Acupuncture diagnosis
   - Treatment goals
   - Treatment strategies
3. Points Used & Procedures Performed
   - Acupuncture points utilized
   - All treatment procedures performed at each visit
   - Including topical applications when provided
4. Practitioner Recommendations
   - Advice and recommendations provided to the patient
5. Diet, Lifestyle, Herbal, and Supplement Instructions
   - When applicable

Florida

6. Herbal/Supplement Dosing Information
    - Dose and timing instructions.
7. Referrals
    - Referrals for additional medical care when appropriate.
8. Patient Progress Notes
    - Ongoing progress and response to care.
9. Laboratory and Imaging Results
    - When appropriate and medically necessary.
10. Date of Service
    - For every encounter.

Board Standard vs. Insurance Standard

A distinction many acupuncturists miss

- **The Acupuncture Board's** standard is a licensing and patient-protection standard requiring complete and accurate records.
- **Insurance carriers** often impose much more stringent documentation requirements to establish medical necessity, support coding, and justify reimbursement.

As a result, a record may satisfy the Board's minimum recordkeeping requirement yet still fail an insurance audit.

Informed Consent

Not every state has an acupuncture statute or regulation that specifically requires a written informed consent form for acupuncture.

However, virtually every state expects practitioners to obtain informed consent as part of the professional standard of care, and many states either explicitly require it or strongly imply it through licensing, patient rights, or healthcare consent laws.

1. Risks of acupuncture
2. Benefits
3. Alternatives
4. Practitioner credentials
5. Clean needle procedures

Informed consent is primarily to protect the patient's right to make an informed decision about their healthcare. However, when done properly, it also protects the provider.

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

Defense relies on records, not recollection

Malpractice Policy Reality

- Typical policy language ties coverage to:
  - “Professional services”
  - “Generally accepted standards of practice”

  - **What that means in practice**:
  - Documentation is assumed
  - Defense is built on the chart
  - Missing or minimal records weaken the case immediately

Bottom Line - Defense attorneys cannot defend what isn’t documented.

Courts

Undocumented care is presumed not provided

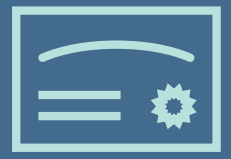
Encounter What Actually Happened

Chart Shows

- Initial intake present
- Subsequent visits:
  - “Adjustment performed”
  - No subjective change noted
  - No objective findings
  - No reassessment markers

Defense Problem

- Cannot prove:
  - Ongoing clinical decision –making
  - Change over time
  - Medical necessity
- Case settles – not because care was bad, but because it was undefendable

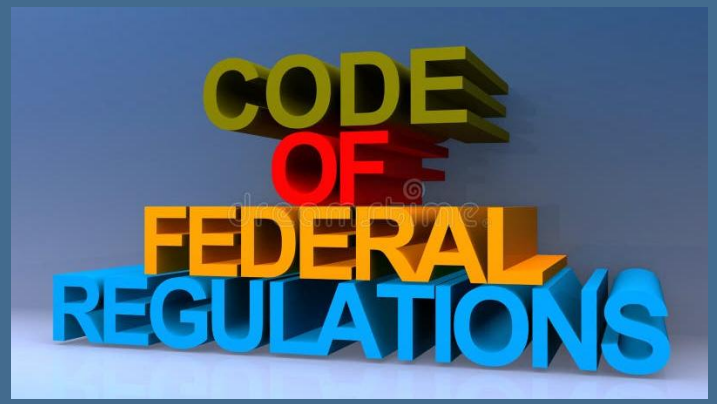


Professional Standards of Care

Documentation is part of accepted acupuncture practice

Corporate Risk Management

Protects both the provider *and* the brand



While there are no federal regulations that prescribe a specific SOAP note format for acupuncture, there are Medicare requirements that effectively create documentation standards whenever acupuncture is billed to Medicare.

Under the Medicare National Coverage Determination (NCD) for acupuncture, documentation must support that the service is **reasonable and necessary** and meets the coverage criteria. CMS specifically states that failure to provide documentation supporting medical necessity may result in claim denial

- Veteran Administration
  - Triwest
  - Optum

- HIPAA does not prescribe how acupuncture treatment notes must be written.
- But does require
  - Protection of patient information
  - Policies regarding record access and disclosure
  - Documentation of privacy and security compliance

HIPAA is primarily a privacy and security law, not a clinical documentation standard.

Electronic Health Record Requirements

There is no federal mandate requiring acupuncture providers use a specific documentation format.

Aetna Clinical Acupuncture and Dry Needling

- Aetna does not publish a separate “acupuncture SOAP note regulation.” Instead, they require documentation through medical necessity and plan-of-care structure.
- If you cannot support medical necessity per Aetna CPB criteria, the claim is not payable — regardless of how well the note is written.

Aetna requires acupuncture to be supported by a written plan of care

- Diagnosis and onset date
- Acupuncture evaluation Specific measurable treatment goals (short- and long-term)
- Frequency and duration of treatment
- Acupuncture treatment protocol
- Expected timeframe for improvement

Ongoing Documentation Requirements

- Regular re-evaluation
- Documentation of measurable improvements
- Evidence that treatment is continuing
- Updates to the plan of care as condition changes
- If no improvement is not demonstrated care is considered not medically necessary
- If symptoms are stable (not improving or worsening)
- If no meaningful improvement after a short trial period (often ~4 weeks in policy logic) further care is not covered

- Aetna reviewers routinely expect:
- Chief complaint / symptom severity
- Functional limitation (work, sleep, ADLs)
- Objective findings (ROM, palpation, etc. if applicable)
- Acupuncture points / technique used
- Response to prior treatment
- Quantified progress (pain scale, function scores)
- Time-based treatment where applicable

Even though not explicitly codified as a "documentation checklist", BCBS audits generally require evidence of:

A. Medical Necessity Foundation

- Diagnosis consistent with covered condition (varies by plan, often pain-based conditions)
- Duration and severity of symptoms
- Prior conservative care (often implied, sometimes required)

B. Treatment Plan

- Frequency and expected duration
- Clinical goals (pain reduction, functional improvement)
- Reason acupuncture is appropriate vs alternatives

C. Ongoing Progress Documentation (critical)

- Pain scale or symptom change over time
- Functional improvement (ADLs, work, sleep)
- Evidence of response to treatment

D. Visit-Level Documentation

- Date of service
- Treatment rendered
- Response to prior treatment
- CPT support (97810–97814 when billed)
- Practitioner identification

MASSACHUSETTS

Billing and documentation best practices for acupuncturists

Print

May 14, 2026

This article is for acupuncturists caring for our members

We're sharing best practices for billing and medical record documentation for acupuncture services.

What's happening: Acupuncturists are billing for services that are not covered in our medical policies, and we've noticed gaps in medical record documentation.

Adhering to Blue Cross medical policies and documentation guidelines may help decrease claim denials and lead to less confusion for members about their coverage and health care costs.

Billing for non-covered services

Collapse All

Medical record documentation standards

Thorough and accurate documentation is essential to validate medical necessity and is a standard record-keeping practice. Adhere to medical record documentation standards as indicated in our *Blue Book* provider manual by:

- **Documenting timed codes**: For any timed services billed, clearly document the start and stop times in the medical record to substantiate the time spent.
- **Signing within seven days**: All records require a signature to be authenticated. For professional medical records, notes must be signed within seven days of the service. We have observed records that are either unsigned or signed after this seven-day period.
- **Demonstrating medical necessity**: Each patient record must contain clear documentation to support the medical necessity of the services rendered. This includes a comprehensive treatment plan and a detailed assessment plan.

Review our Medical and Behavioral Health Record Guidelines in our *Blue Book* provider manual. Log in and go to Office Resources>Provider Manuals to find this document.

MASSACHUSETTS

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June 22 update: In the billing for non-covered services section, we've removed reference to CPT 97026. That is a covered, reimbursable service.

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What's happening: Acupuncturists are billing for services that are not covered in our medical policies, and we've noticed gaps in medical record documentation.

Adhering to Blue Cross medical policies and documentation guidelines may help decrease claim denials and lead to less confusion for members about their coverage and health care costs.

Billing for non-covered services

Collapse All

Stop billing for services that are not covered:

- **Cupping therapy (CPT 97016)**: This is considered not medically necessary and is a non-covered service. Refer to a list of services considered not medically necessary in our medical policy 178, Complementary Medicine

Medical record documentation standards

Thorough and accurate documentation is essential to validate medical necessity and is a standard record-keeping practice. Adhere to medical record documentation standards as indicated in our *Blue Book* provider manual by:

- Cigna CPG024 Medical Coverage Policy- Therapy Services, Acupuncture
- Documentation expectations for acupuncture is centered on one concept: the record must demonstrate medical necessity and improvement.

Initial evaluation

- History and exam relevant to the complaint
- Standardized and non-standardized assessments
- Functional status (objective and subjective)
- Clinical reasoning and diagnosis
- Plan of care with treatment techniques
- Frequency and duration (“dose”)
- Measurable short- and long-term goals
- Prognosis and discharge plan

Treatment Plan

- Specific acupuncture techniques used
- Treatment frequency and duration
- Measurable functional goals
- Expected timeframe for improvement
- Updates as condition changes

Visit Documentation

- Date of service
- Specific treatment provided (must match CPT codes 97810–97814)
- Total treatment time
- Patient response to treatment
- Ongoing reassessment of progress toward goals
- Measurable improvement or lack of improvement
- Barriers or modifications to plan
- Clinician name/credentials

Should you be concerned about audits?

Accuracy, Clarity, and Guidelines

What Triggers Audits?

Less about *format* and more about medical necessity, utilization patterns, and documentation consistency.

- Extended care for non-complicated conditions
- Maintenance care patterns
- Non-covered or weak diagnosis
- High frequency of visits
- High value EM 99205/99215 or frequent use of E&M
- Patient/Employee making complaints to the insurer

Anthem

May 13, 2026

[redacted]

RE: **Medical Record Request**

Dear [redacted]

In an effort to combat fraud, waste, and abuse (FWA) the Special Investigations Unit (SIU) is conducting an assessment of services rendered to our member(s) and/or their dependents. Our reviews aim to verify whether services are billed accurately and can be supported through documentation, such as Anthem policies and guidelines, the American Medical Association (AMA) Current Procedural Terminology (CPT) and/or Healthcare Common Procedural Coding System (HCPCS) and any other applicable industry standards.

What to Supply

Examples of acceptable documentation include, but are not limited to:

Referring physician orders

Procedure records

Telehealth records

Test results

Office service records

Facility reports

Radiology reports

Treatment records

Electronic records user access logs

Please submit the requested medical records by **June 13, 2026**.

Records should be submitted either by mail or electronically through the Availity portal.

Case number: [redacted] Provider [redacted] Investigator: [redacted]

Melisa Francis
Investigator
Special Investigations Unit (SIU)

Cigna.

[redacted]

February 25, 2026

CONFIDENTIAL
VIA CERTIFIED FEDEX MAIL

[redacted]

RE: Retrospective Review Findings

Dear Dr. [redacted]

Cigna routinely monitors and conducts external audits in order to meet its obligations to customers, healthcare professionals, clients and government programs. As part of our routine monitoring and auditing, we recently conducted a post-payment review of services submitted under tax identification number 27-2239242. Billing and collection records were requested and a comprehensive review was performed, which included an examination for collection attempts of Cigna customers' cost share obligations. The audit has identified damages in the amount of $1,183,050.90.

What this means to you:

For this audit, Cigna originally requested medical records for 41 patients as part of a statistically valid random sample. The sampling frame included claims processed between January 16, 2021 – August 10, 2024. You agreed to our review of a reduced sample of medical records for 20 patients as part of a probe sample. By accepting this reduced sample size, you acknowledged that the records selected are a fair and accurate representation of your services. Additional billing and collection records were also requested for the patients in the negotiated sample. The records were reviewed by the Special Investigations Unit.

The findings of Cigna's retrospective review revealed that the documentation did not justify the claims paid. Our review identified several significant issues, as noted below, where Plan and/or other relevant requirements were not satisfied.

Finding 1: Fee Forgiving

A review of the billing and collections documents provided show that patients are only being held responsible for small amounts that would not be sufficient to pay off the total out-of-network balances owed. Most patients have a payment plan and/or a financial hardship agreement on file, but there was no documentation to show how financial hardship was determined.

Finding 2: Services Not Rendered As Billed

CPT Code 97112 – Neuromuscular Reeducation, 1 or more areas, each 15 minutes – The records documented various Pilates technique. However, according to Cigna Medical Coverage Policy for Physical Therapy Services (CPG135), "Therapy services that do not require the skills of a qualified provider of PT services. Examples include but are not limited to: Activities for the general good and welfare of patients, General exercises (basic aerobic, strength, flexibility or aquatic programs) to promote overall fitness/conditioning, Services/programs for the primary purpose of enhancing or returning to athletic or recreational sports. Massages and whirlpools for relaxation"

CPT Code 97140 – Manual Therapy Techniques, 1 or more regions, each 15 minutes - The medical records include documentation of soft tissue massage for manual therapy, and according to Cigna Medical Coverage Policy for Physical Therapy Services (CPG135), Therapy services that do not require the skills of a qualified provider of PT services. Examples include but not limited to: Activities for the general good and welfare of patients, General exercises (basic aerobic, strength, flexibility or aquatic programs) to promote overall fitness/conditioning, Services/programs for the primary purpose of enhancing or returning to athletic or recreational sports. Massages and whirlpools for relaxation"

CPT Code 97810 – Acupuncture, 1 or more needles, without electrical stimulation, initial 15 minutes – There was one instance where the medical records did not include acupuncture treatment on the billed date of service.

CPT Code 97811 – Acupuncture, 1 or more needles, without electrical stimulation, additional 15 minutes - There was one instance where the medical records did not include acupuncture treatment on the billed date of service.

There were several instances where there were no medical records for the date of service in question.

Finding 3: Cloning

CPT Code 97811 – Acupuncture, 1 or more needles, without electrical stimulation, additional 15 minutes - Although the medical records include acupuncture, the patient's progress is cloned from other dates of service and not continuously updated. According to Cigna's Medical Coverage Policy for Acupuncture (CPG024), "DOCUMENTATION GUIDELINES:
Treatment Sessions: Acupuncture treatment can vary from Acupuncture alone (CPT codes 97810, 97811, 97813, 97814) to the use of a variety of modalities and procedures depending on the patient's condition, response to care, and treatment tolerance. All services must be supported in the treatment plan and be based on an individual's clinical condition. An acupuncture treatment session may include:

- A brief evaluation of the patient's progress and response to previous treatment(s);
- Acupuncture with or without electric stimulation
- Related passive modalities (e.g.: indirect moxibustion, hot/cold packs
- Functional education in self-care and home management
- Reassessment of the individual's condition, diagnosis, plan, and goals as part of the treatment session
- Coordination, communication, and documentation
- Reevaluation, if there is a significant change in the individual's condition or need to update and modify the treatment plan".

Finding 4: Incorrect Coding / Incorrect Units

CPT Code 97811 – Acupuncture, 1 or more needles, without electrical stimulation, additional 15 minutes - Although acupuncture treatment was provided, an add-on CPT code was reported without a primary procedural

CPT code. According to CPT Coding Guidelines, add-on CPT codes are not stand-alone codes and are always reported with a primary procedure code.
There was also one instance where the medical records included an additional 15 minutes of acupuncture treatment, however, 30 minutes (2 units) was billed.

CPT Code 97140 - Manual Therapy Techniques, 1 or more regions, each 15 minutes – The medical records documented 15 minutes of manual therapy, but 30 minutes (2 units) was billed.

Finding 5: Insufficient Documentation

CPT Code 97811 – Acupuncture, 1 or more needles, without electrical stimulation, additional 15 minutes – There was no documentation of an initial evaluation to support the submission of the CPT code. According to Cigna's Medical Coverage Policy for Acupuncture (CPG024), "Evaluation: An initial evaluation service is essential to determine whether any acupuncture services are medically necessary, to gather baseline data, establish a treatment plan, and develop goals based on the data. The initial evaluation service must include: an appropriate level of clinical history, examination, and medical decision-making relevant and appropriate to the individual's complaint(s) and presentation;

- Subjective historical evaluation based on standardized method such as the 10 questions;
- Specific standardized and non-standardized tests, assessments, and tools;
- Interpretation and synthesis of all relevant clinical findings derived from history and physical examination for the purpose of clinical decision-making;
- Subjective and objective measurable, description of functional status using comparable and consistent methods;
- Summary of clinical reasoning and consideration of contextual factors with recommendations;
- The establishment of a working diagnosis;
- Plan of care with specific treatment techniques or activities to be used in treatment sessions that should be updated as the individual's condition changes;
- Frequency and duration of treatment (treatment dose);
- Functional, measurable, and time-framed long-term and short-term goals based on appropriate and relevant evaluation data; and
- Prognosis and discharge plan"

Finding 6: Unbundling / Not a Reimbursable Service

- According to NCCI edits, the CPT Codes below are inclusive to CPT code 97810 and 97811. Additionally, according to Cigna Reimbursement Policy (M25), Modifier 25-Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service, "In general, reimbursement for evaluation and management (E/M) services on the same day a procedure is also performed by the same physician is included in the payment for the procedure. The E/M service code should not be separately reported."
    - **CPT Code 99203** - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
    - **CPT Code 99213** - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
    - **CPT Code 99202** - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

must meet or exceed 30 minutes of total time (non-face to face and face to face total time) spent on the date of the encounter. However, the medical records submitted don't support low level medical decision making or total time required of the code billed. This means the validity and accuracy of the billed service and appended modifier can't be verified.

Date	CPT Code	Mod	CPT Description	Claim Amount	Denial Code	Reason
03/17/2026 to 03/17/2026	97813		ACUPUNCTURE 1/> NDLS W/ELEC STIMJ 1ST 15 MIN	$100	HP	The information submitted does not contain sufficient detail to support all related charges billed.

Claim/Coding Logic

Not supported. The submitted medical records don't support that 97813 was performed. The documentation submitted doesn't indicate the time spent was personal one-on-one contact with the patient. Of note, acupuncture personal one-on-one contact time that is less than 8 minutes isn't separately reported. This means the validity and accuracy of the billed service can't be verified.

Date	CPT Code	Mod	CPT Description	Claim Amount	Denial Code	Reason
03/17/2026 to 03/17/2026	97814		ACUP 1/> NDLS W/ELEC STIMJ EA 15 MIN W/RE-INSJ	$125	OW	Claim cannot be processed as billed. This code requires a preceding procedure code.

Claim/Coding Logic

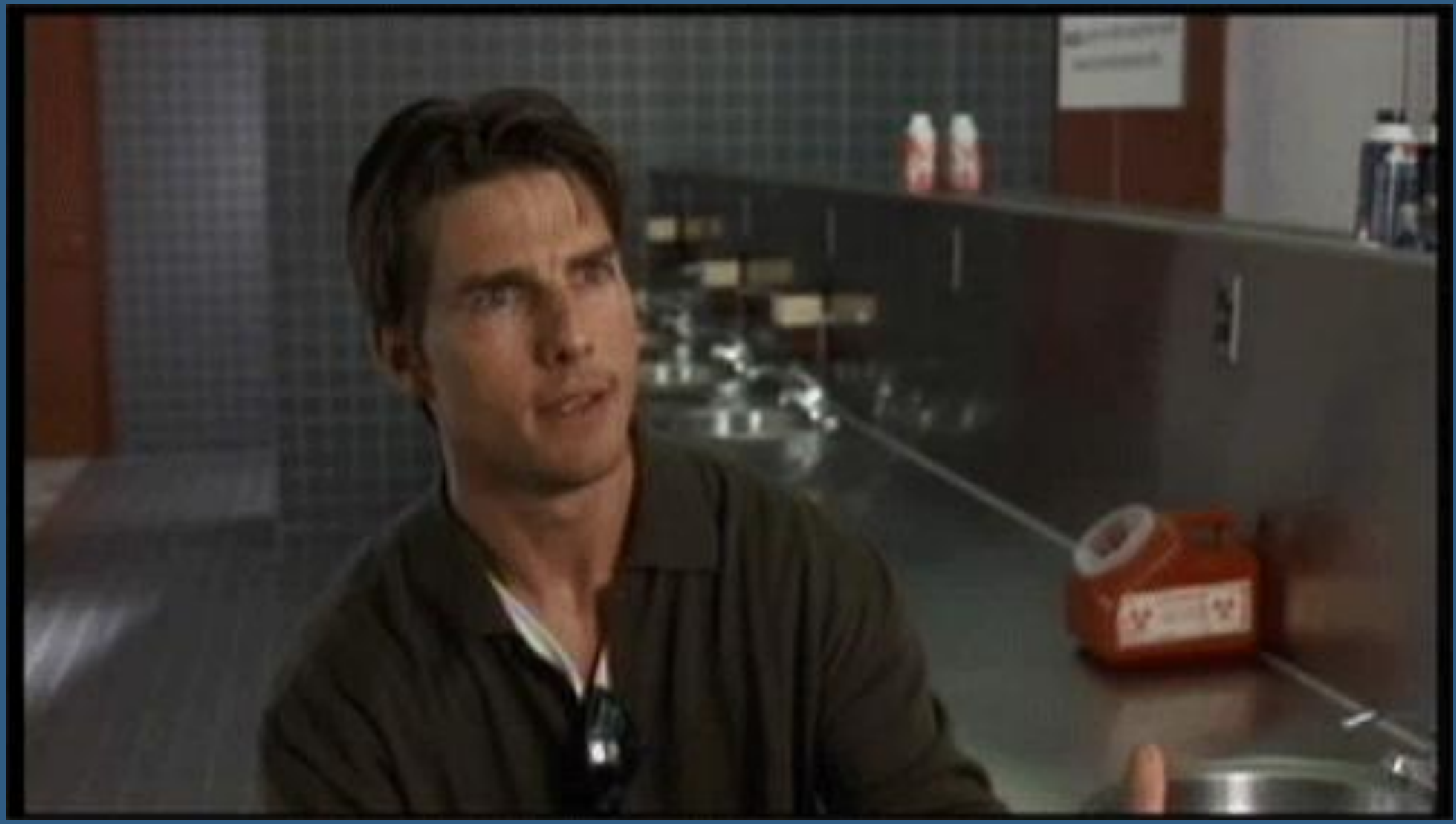
Not supported. This is an add-on type code that requires a primary code. Since the primary code isn't supported, this code can't be separately reimbursed. In addition, the submitted medical records don't support that 97814 was performed. The documentation submitted doesn't indicate the time spent was personal one-on-one contact with the patient. Of note, acupuncture personal one-on-one contact time that is less than 8 minutes isn't separately reported. This means the validity and accuracy of the billed service and units can't be verified.

Date	CPT Code	Mod	CPT Description	Claim Amount	Denial Code	Reason
03/17/2026 to 03/17/2026	97814		ACUP 1/> NDLS W/ELEC STIMJ EA 15 MIN W/RE-INSJ	$125	OW	Claim cannot be processed as billed. This code requires a preceding procedure code.

Claim/Coding Logic

Not supported. This is an add-on type code that requires a primary code. Since the primary code isn't supported, this code can't be separately reimbursed. In addition, the submitted medical records don't support that 97814 was performed. The documentation submitted doesn't indicate the time spent was personal one-on-one contact with the patient. Of note, acupuncture personal one-on-one contact time that is less than 8 minutes isn't separately reported. This means the validity and accuracy of the billed service and units can't be verified.

Date	CPT Code	Mod	CPT Description	Claim Amount	Denial Code	Reason



Practical Standards

1. Why did the patient seek treatment?
2. What objective findings support the diagnosis?
3. What treatment was provided on that date?
4. Why was the treatment medically necessary?
5. How did the patient respond?
6. Does the documentation support the CPT codes billed?

If the record does not support those elements, auditors often take the position that the service was either not documented or not medically necessary, even if the treatment was actually performed.

2026 Department of Health and Human Services Compliance Program

Documentation, Coding, Billing, Medical Necessity, HIPAA-Privacy

Each practice can undertake reasonable steps to implement compliance measures, depending on the size and resources of that practice. Practices can rely, at least in part, upon standard protocols and current practice procedures to develop an appropriate compliance program for that practice. Many practices already have established the framework of a compliance program without referring to it as such.

The incorporation of compliance measures into a physician's practice should not be at the expense of patient care but instead should augment the ability of the physician's practice to provide quality patient care.

7 Components of an Effective Compliance Program This compliance program guidance for individual and small-group practices

1. Conducting internal monitoring and auditing.
2. Implementing compliance and practice standards.
3. Designating a compliance officer or contact.
4. Conducting appropriate training and education.
5. Responding appropriately to detected offenses and developing corrective action.
6. Developing open lines of communication.
7. Enforcing disciplinary standards through well-publicized guidelines.

A well-designed compliance program can:

- Speed and optimize proper payment of claims;
- Minimize billing mistakes;
- Reduce the chances that an audit will be conducted by HCFA or the OIG; and
- Avoid conflicts with the self-referral and anti-kickback statutes. (fee-splitting)

A self-audit is an audit, examination, review, or other inspection performed by and within a physician's or other healthcare professional's business. Self-audits generally focus on assessing, correcting, and maintaining controls to promote compliance with applicable laws, rules, and regulations. The U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG), includes periodic internal monitoring and auditing in its list of the seven elements of an effective compliance program.[1]

1 Federal Register Vol. 65, No. 194. (2000, October 5). Office of Inspector General. OIG Compliance Program for Individual and Small Group Physician Practices. Retrieved December 18, 2017, from https://oig.hhs.gov/authorities/docs/physician.pdf

Record Keeping Basics

- Accurate, complete, timely, legible, and able to support the care rendered and the charges billed.
- Electronic Health Records have essentially eliminated legibility

Electronic Medical Records

Improved Documentation Accuracy and Legibility

- EMRs eliminate handwriting issues and help ensure legible, complete, and consistent notes.
- Built-in templates for SOAP notes and CPT/ICD coding reduce human error.

Efficiency and Workflow Management

- Pre-filled templates and customizable macros allow acupuncturists to document repetitive visits quickly.
- Scheduling, billing, and documentation are often integrated in one system, streamlining front-desk to back-office workflow.
- Instant access to prior visits, and treatment plans improves continuity of care.

Cloning – Cut & Paste

- Documentation cloning is not prohibited outright, but cloned records that fail to reflect the patient's actual condition on that specific date of service are considered unacceptable and can lead to claim denials, recoupments, and audit findings. (OIG & CMS)
- Cloned documentation that does not account for patient-specific variations is considered a misrepresentation of medical necessity and may result in claim denial.
- Documentation is considered cloned when entries are exactly or substantially the same from one encounter to another or from one patient to another. CMS takes the position that cloned documentation does not support medical necessity because it lacks individualized information.

Avoid

- Not documenting time and referencing time is face-to-face
- Identical SOAP notes across multiple visits.
- The same subjective complaints repeated visit after visit.
- Unchanged objective findings for weeks or months.
- Identical treatment plans with no evidence of reassessment.
- Copy-forward notes where only the date changes.
- The same findings appear across different patients

Macros

- Templates and EHR macros should still demonstrate and record:
- The patient’s subjective condition that day.
- Objective findings that day.
- Treatment provided that day.
- Response to treatment.
- Progress (or lack of progress).
- Medical necessity for continued care.

Authentication

- Medical records submitted to substantiate services rendered or ordered must be appropriately signed and credentialed.

- Acceptable signatures include handwritten signatures, initials over a typed or printed name, or authenticated electronic signatures. An electronic signature usually contains a date and timestamp, and a printed statement, such as, “electronically signed by” or “verified/reviewed by,” followed by the practitioner’s name and professional designation. Stamped signatures are not acceptable, nor are indications that a document has been, “signed but not read.”

- Handwritten signatures
- Electronic signatures
- Digital signatures

- Legible or identifiable
- Dated (or date/time stamped by the system)
- Linked to the individual who performed the service
- If legibility is an issue maintain a signature log

- Electronically signed and authenticated by Jane Doe on 06/18/2026 at 9:15 AM.

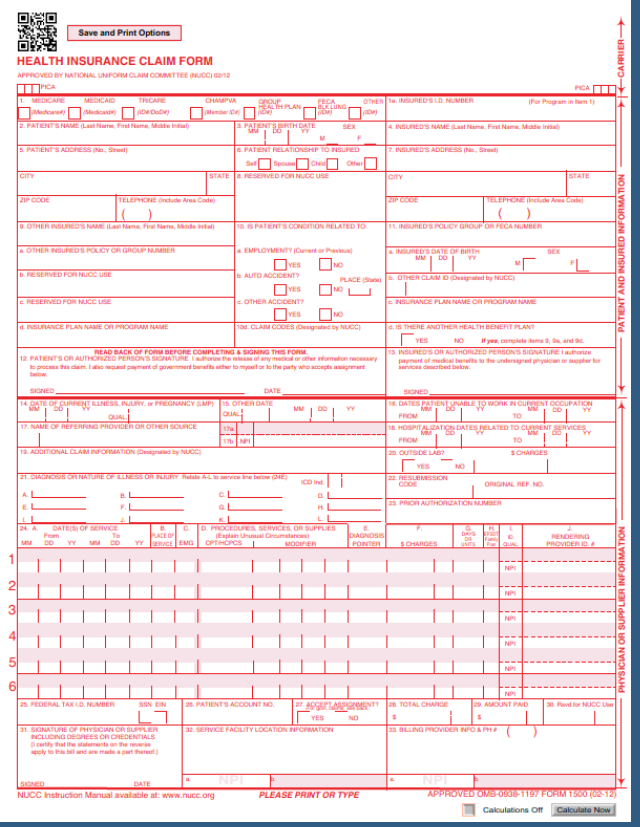
CMS E signature examples

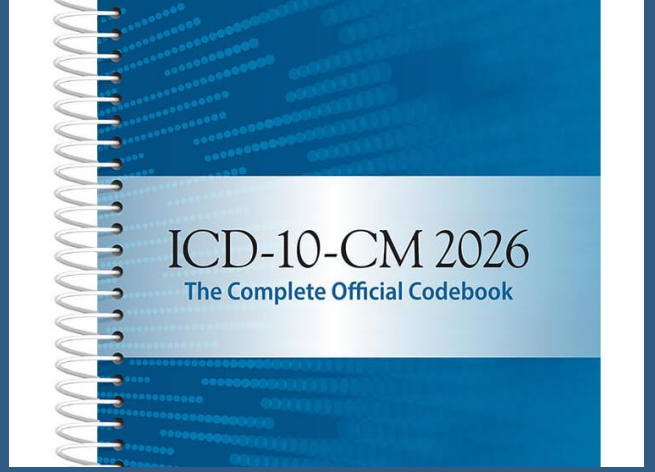
- Chart "Accepted by" with provider's name
- "Electronically signed by" with provider's name
- 'Verified by" with provider's name
- "Reviewed by" with provider's name
- "Released by" with provider's name
- "Signed by" with provider's name
- "Signed before import by" with provider's name
- "Signed: John Smith, M.D." with provider's name
- Digitized signature: Handwritten and scanned into the computer
- "This is an electronically verified report by John Smith, M.D."
- "Authenticated by John Smith, M.D."
- "Authorized by: John Smith, M.D."
- "Digital signature: John Smith, M.D."
- "Confirmed by" with provider's name
- "Closed by" with provider's name
- "Finalized by" with provider's name
- "Electronically approved by" with provider's name
- "Signature derived from controlled access password"

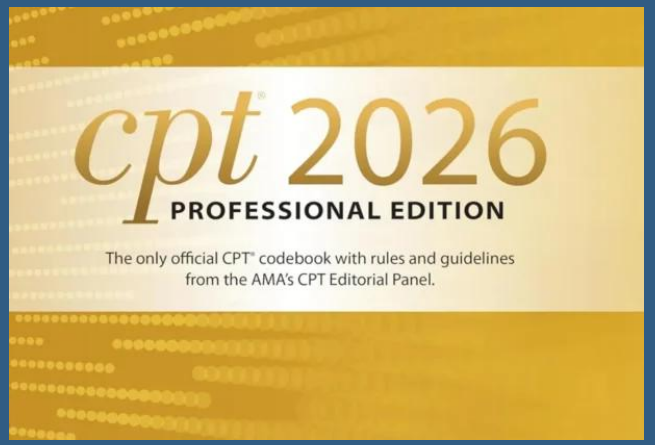
Timeliness of Documentation

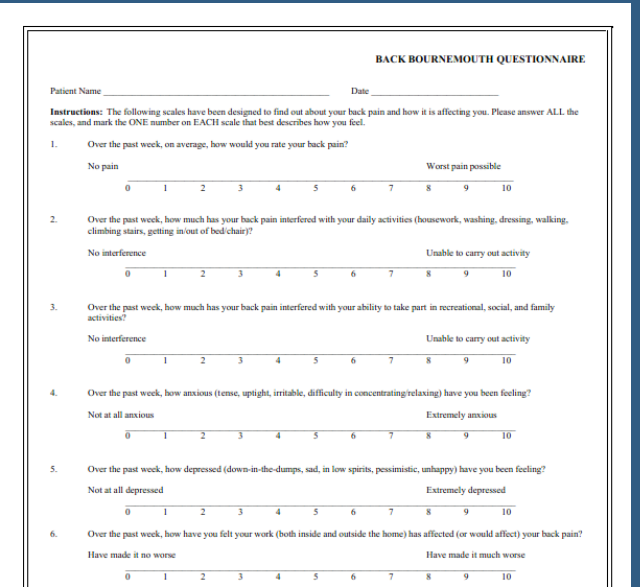
It is expected that documentation will be generated at the time a service is rendered or as soon as practicable after it is provided to maintain an accurate medical record. A reasonable expectation would be to complete documentation no more than 24-48 hours away from the service itself. Delayed entries within a reasonable time are acceptable for purposes of clarification, error correction, addition of information not initially available, or if unusual circumstances prevented the generation of the note at the time of service. Anything after 48 hours may be considered unreasonable.

- The medical record cannot be altered. Any errors identified after the original record is complete must be legibly corrected in a manner that allows the reviewer to identify what is being corrected and why.
- If you need to make a correction (late entry) to a written medical record, you should never write over, erase, or delete the original entry. You should draw a single line through the erroneous information, leaving the original entry still legible. Sign or initial and date the deletion and include a reason for the correction above or in the margin or within the correction. Document the correct information with the current date and signature or initial.
- Electronic records should follow the same principle of being able to identify the original entry, the correction, the date and time of the correction, the reason the record is being corrected and the person making the correction. Any hard copies of the electronic record must show the original entry and the correction.









BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

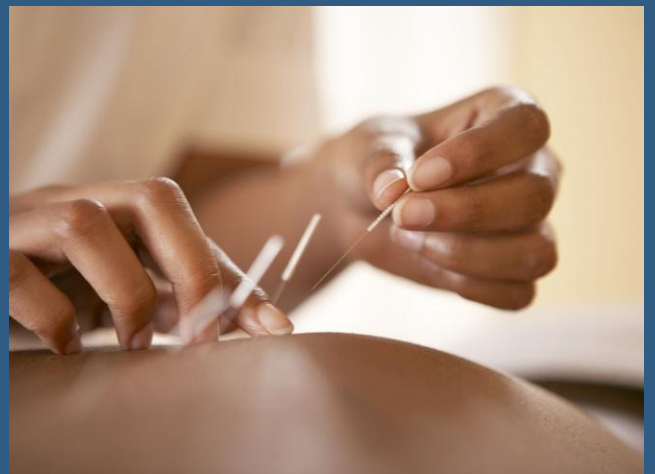
Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10



Algorithm of Patient Management & Documentation

1. History & Examination
2. Diagnosis
3. Treatment
4. Outcome
5. Billing & Payment

It starts with a good intake.

ACUPUNCTURE INTAKE & MEDICAL NECESSITY FORM

Patient Information

- Patient Name: _____
- Date of Birth: _____
- Sex: ☐ Male ☐ Female ☐ Other

Chief Complaint (Primary Reason for Visit)

- Main complaint today: _____
- Location of symptoms: _____
- Duration of condition: _____
- Manifestation Onset: ☐ Sudden ☐ Gradual ☐ Injury-related ☐ Unknown

_____

Pain / Symptom Severity (Required for Medical Necessity)

- Current severity (0–10): _____
- Worst severity (0–10): _____
- Best severity (0–10): _____
- Frequency: ☐ Constant ☐ Intermittent ☐ Occasional

Functional Impact (Required for Insurance Coverage)

Check all that apply:

- ☐ Difficulty sleeping
- ☐ Difficulty working
- ☐ Difficulty sitting/standing/walking
- ☐ Reduced exercise tolerance
- ☐ Difficulty performing ADLs (bathing, dressing, lifting)
- ☐ Reduced quality of life

Describe functional limitations:

_____

_____

Temperature Regulation

- Do you tend to feel hot or cold?
- Do you have cold hands or feet?
- Do you experience night sweats?
- Do you sweat excessively?
- Are you bothered by drafts or wind?

Sleep

- How many hours do you sleep?
- Difficulty falling asleep?
- Difficulty staying asleep?
- Wake between specific hours?
- Vivid dreams?
- Do you feel rested upon waking?

Energy

- What is your energy level on a scale of 1-10?
- Time of day when energy is lowest?
- Do you experience fatigue after meals?
- Do you require caffeine to function?

Energy Digestion Bowel Habits Emotional Stress Women's/Men's Health

History of Present Illness

- Prior treatments attempted:
  ☐ Physical therapy
  ☐ Chiropractic care
  ☐ Medications
  ☐ Injections
  ☐ Surgery
  ☐ Other: _____
- Response to prior treatment:
  ☐ No improvement ☐ Mild improvement ☐ Moderate improvement ☐ Significant improvement

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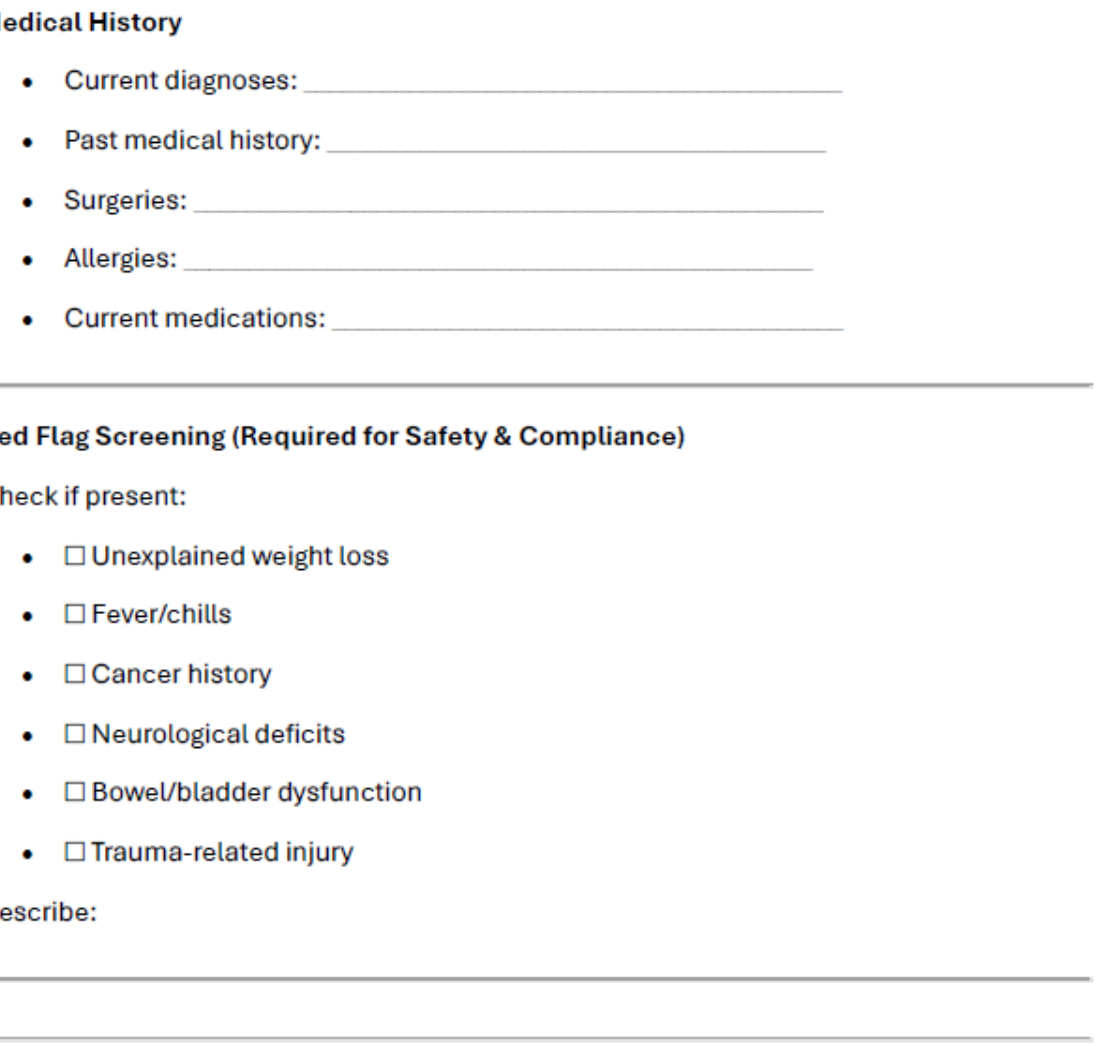


edical History

- Current diagnoses: _____
- Past medical history: _____
- Surgeries: _____
- Allergies: _____
- Current medications: _____

---

ed Flag Screening (Required for Safety & Compliance)

heck if present:

- ☐ Unexplained weight loss
- ☐ Fever/chills
- ☐ Cancer history
- ☐ Neurological deficits
- ☐ Bowel/bladder dysfunction
- ☐ Trauma-related injury

escribe:

For an insurance-based acupuncture practice, the intake should not rely solely on traditional acupuncture questions.

Best Practice Intake:

Medical Necessity Section

- Chief complaint
- Pain scale
- Functional limitations
- Prior treatment history
- Outcome measures (Oswestry, Neck Disability Index, Quick DASH, etc.)
- Goals of care

Acupuncture Assessment Section

- Sleep
- Digestion
- Temperature
- Energy
- Stress
- Menstrual history
- Tongue findings
- Pulse findings

For an audit, the medical necessity section is what typically protects reimbursement; the acupuncture-specific section aids clinical decision-making and supports the acupuncture diagnosis.

1. History
2. Examination
3. Medical Decision Making
4. Counseling
5. Coordination of care
6. Nature of presenting problem
7. Time

EVALUATION & MANAGEMENT

NEW PATIENT
A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

99202 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15-minutes must be met or exceeded.

99203 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99204 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99205 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

ESTABLISHED PATIENT
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

99211 **Office or other outpatient visit** for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.

99212 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

99213 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 -minutes must be met or exceeded.

99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99215 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

History
- Complaints
- Complications
- Comorbidities

Exam
- Objective & Quantified
- Validated outcome tools

Diagnoses

Counseling -Plan of care (ROF)

DOCUMENTATION GUIDELINES

Evaluation: An initial evaluation service is essential to determine whether any acupuncture services are medically necessary, to gather baseline data, establish a treatment plan, and develop goals based on the data. The initial evaluation service must include: An appropriate level of clinical history, examination, and medical decision-making relevant and appropriate to the individual's complaint(s) and presentation;

- Subjective historical evaluation based on standardize method such as the 10 questions;
- Specific standardized and non-standardized tests, assessments, and tools;
- Interpretation and synthesis of all relevant clinical findings derived from history and physical examination for the purpose of clinical decision-making;
- Subjective and objective measurable, description of functional status using comparable and consistent methods;
- Summary of clinical reasoning and consideration of contextual factors with recommendations;
- The establishment of a working diagnosis;
- Plan of care with specific treatment techniques or activities to be used in treatment sessions that should be updated as the individual's condition changes;
- Frequency and duration of treatment (treatment dose);
- Functional, measurable, and time-framed long-term and short-term goals based on appropriate and relevant evaluation data; and
- Prognosis and discharge plan.

Evaluation & Management Documentation

History

1. Symptoms causing patient to seek treatment.
2. Quality and character of symptoms/problem.
3. Onset, duration, intensity, frequency, location and radiation of symptoms
4. Aggravating or relieving factors. Mechanism of trauma.
5. Prior interventions, treatments, medication and secondary complaints
6. Past health history as well as family history if relevant.

A. History as noted with the symptoms bearing a direct causal relationship to the diagnosis.

B. Evaluation of through physical examination.

C. Diagnosis

D. Treatment plan: recommended duration and frequency of visits. This should include specific and expected goals and the response to care. Objective measures to evaluate treatment effectiveness.

Time

- **99202** Meet or exceed 15 min
- **99212** 10 min
- **99203** 30 minutes
- **99213** 20 minutes
- **99204** 45 minutes
- **99214** 30 minutes
- **99205** 60 minutes
- **99215** 40 minutes

Medical Decision Making *

- **99202/99212** 1 self-limited or minor problem
- **99203/99213** 2 or more complaints / acute injury
- **99204/99214** Acute/Chronic complicated injury
- **99205/99215** Threat to life or bodily function

Documentation

- 45 minutes was spent on E&M including record review, face-to-face time with the patient for history, examination, report of findings, treatment plan, and counseling.

- Medical decision-making categorizes the E&M service with a moderate level of decision-making related to the acute severity and complicating factors associated with the injury.

History + Examination = Diagnoses

Know the plan you are billing and what the accepted conditions for payment are

2026 Acupuncture Common Code List

- Lower back pain
- Neck pain
- Shoulder pain
- Hip pain
- Knee pain (osteoarthritis)
- Headache disorders
- TMJ
- Nausea and vomiting

70-80% of reimbursable acupuncture claims fall into musculoskeletal pain conditions

Treatment Plan

What is wrong, what are we trying to accomplish, how are we going to do it, and how long should it take?

- Focus on functional changes and how the condition affects daily activities
  - Unable to sit more than 20 minutes without pain.
  - Difficulty lifting more than 15 pounds.
  - Sleep interrupted 3–4 times per night.
  - Unable to work full duty.
  - Unable or limited ability to exercise.

Treatment Goals - Measurable and Time-Based

Short Term 2-4 weeks

- Reduce pain from 8/10 to 4/10.
- Increase lumbar flexion by 25%.
- Improve sleep quality.
- Reduce muscle spasm.
- Improve sitting tolerance to 45 minutes.

Long Term Goals 6-12 weeks

- Pain 0–2/10.
- Full or functional range of motion.
- Return to normal work duties.
- Return to social and recreational activities.
- Independent home exercise program.

Frequency and Duration

- **Phase I:** Acute Care 2–3 visits per week for 2–4 weeks. Reduce pain and inflammation
- **Phase II:** Corrective/Rehabilitative Care 1–2 visits per week for 2–6 weeks. Reduce pain from 7/10 to 4/10. Improvement of ADL and reduction of sleep disturbances
- **Phase III:** Functional recovery and transition to Independent self-management. Pain reduced to 2-3/10, sleep[throughout the night & return to normal activities and exercise

Anthem

- A written plan of treatment relating to the type, amount, frequency, and duration of care is required for all members. The plan of care must be updated as the member's condition changes. A treatment plan is not valid for longer than 90 calendar days from the first treatment day under the certified treatment plan.

Avoid

“Treat as needed. Continue treatment.“

That type of plan does not establish medical necessity, measurable goals, or an expected endpoint for care.

TREATMENT

Scope of practice

- Acupuncture
- Physical medicine and rehabilitation
- Injections

American Acupuncture Council NETWORK

ACUPUNCTURE CODES

CPT Codes

97810	Acupuncture, one or more needles: without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.
97811	without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
97813	Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97814	with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

Definition of the 15-Minute Acupuncture Time Increment

The 15-minute time increment is defined as direct, one-on-one patient contact time with the physician or qualified healthcare professional. During this time, the provider must be actively engaged in medically necessary acupuncture-related services, which may include patient assessment, review of interval history, evaluation of response to treatment, selection and preparation of acupuncture points, skin preparation, insertion and manipulation of needles, application or adjustment of electrical stimulation when applicable, and needle removal and disposal.
Time during which needles remain retained in the patient is not counted toward timed service units.
Time-Based Unit Calculation (8-Minute Rule Methodology) reported based on total documented face-to-face treatment time as follows:

- 1 unit: 8–22 minutes of qualifying one-on-one treatment time
- 2 units: 23–37 minutes of qualifying one-on-one treatment time
- 3 units: 38–52 minutes of qualifying one-on-one treatment time
- 4 units: 53–67 minutes of qualifying one-on-one treatment time

Each additional unit requires additional qualifying face-to-face time with active treatment intervention (e.g., additional needle insertion/manipulation or electroacupuncture application).

Documentation Best Practice
Document start and stop times (clock time) rather than estimating total minutes, as many payers require or strongly prefer time substantiation based on actual recorded treatment duration rather than rounded or inferred totals.

Do I need to reinsert needle(s) to bill the add-on codes 97811 or 97814? Yes. According to the CPT Assistant, June 2005/Volume 15, Issue 6, "re-insertion of the needle(s) is required to use add-on codes 97811 and 97814.

May I mix and match electrical and non-electrical stimulation procedures in the same session? Yes. Only one initial acupuncture code is reported per session per day, as both represent the initial needle insertion set. Therefore, 97810 and 97813 should not be billed together on the same date of service.
Additional treatment time may be reported with 97811 or 97814, as appropriate, and these add-on codes may be used with either allowable initial code, depending on the modality used during the session.

Acupuncturists/East Asian Medicine Practitioners

Billing Guidelines

All claims must include both the International Classification of Diseases, Ninth Revision (ICD-9) and Current Procedural Terminology (CPT®) codes to ensure accurate processing. The diagnosis must match the diagnosis of the referring physician.

When billing for acupuncture services, please use:

- **CPT 97810** *Acupuncture, one or more needles; without electrical stimulation, initial 15 minutes of personal one on one contact with patient*
- **CPT 97811** *Acupuncture, one or more needles; without electrical stimulation, each additional 15 minutes of personal one on one contact with the patient, with reinsertion of needle(s) (List separately in addition to code for primary procedure)*
- **CPT 97813** *Acupuncture, one or more needles; with electrical stimulation, each additional 15 minutes of personal one on one contact with patient*
- **CPT 97814** *Acupuncture, one or more needles; with electrical stimulation, each additional 15 minutes of personal one on one contact with patient, with reinsertion of needle(s) (List separately in addition to code for primary procedure)*

CPT 97810 and **97813** will not be allowed when billed together for the same visit.

Only one unit of service for **CPT 97810** and **97813** is allowed per date of service, up to the benefit maximum. **CPT 97811** and **97814** must be explicitly denoted in the patient's medical record to be allowed.

8 Minute Rule for Timed Codes – One Service
For services billed in 15-minute units, count the minutes of skilled treatment provided. Only direct, face-to-face time with the patient is considered for timed codes.

- 7 minutes or less of a single service is not billable.
- 8 minutes or more of a single service is billable as 1 unit or an additional unit if the prior units were each furnished for a full one.

15 minutes:

- 8 – 22 minutes = 1 unit
- 23 – 37 minutes = 2 units
- 38 – 52 minutes = 3 units

Note: Evaluation and management (E&M) codes cannot be used as a substitute for acupuncture treatments.

Billing and documentation best practices for acupuncturists

Print

May 14, 2026

This article is for acupuncturists caring for our members

We're sharing best practices for billing and medical record documentation for acupuncture services.

What's happening: Acupuncturists are billing for services that are not covered in our medical policies, and we've noticed gaps in medical record documentation.

Adhering to Blue Cross medical policies and documentation guidelines may help decrease claim denials and lead to less confusion for members about their coverage and health care costs.

Billing for non-covered services

Collapse All

Medical record documentation standards

Thorough and accurate documentation is essential to validate medical necessity and is a standard record-keeping practice. Adhere to medical record documentation standards as indicated in our *Blue Book* provider manual by:

- **Documenting timed codes**: For any timed services billed, clearly document the start and stop times in the medical record to substantiate the time spent.
- **Signing within seven days**: All records require a signature to be authenticated. For professional medical records, notes must be signed within seven days of the service. We have observed records that are either unsigned or signed after this seven-day period.
- **Demonstrating medical necessity**: Each patient record must contain clear documentation to support the medical necessity of the services rendered. This includes a comprehensive treatment plan and a detailed assessment plan.

Review our Medical and Behavioral Health Record Guidelines in our *Blue Book* provider manual. Log in and go to Office Resources>Provider Manuals to find this document.

Counting Time as a Function of Work
Pre-service time includes assessment and management time - medical record review, physician contact while the patient is present, assessment of the patient's progress since the previous visit, and time required to establish clinical judgment for the treatment session. Pre-service time is not the time required to get the patient ready to receive the treatment.
Intra-service time includes the hands-on treatment time.
Post-service time includes the assessment of treatment effectiveness, communication with the patient/caregiver to include education/instruction/counseling/advising, professional communications, clinical judgment required for treatment planning for the next treatment session, and documentation while the patient is present.

Counting Minutes for Timed Codes in 15 Minute Units
When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:
Units Number of Minutes
1 unit: ≥ 8 minutes through 22 minutes
2 units: ≥ 23 minutes through 37 minutes
3 units: ≥ 38 minutes through 52 minutes
4 units: ≥ 53 minutes through 67 minutes
5 units: ≥ 68 minutes through 82 minutes
6 units: ≥ 83 minutes through 97 minutes
7 units: ≥ 98 minutes through 112 minutes
8 units: ≥ 113 minutes through 127 minutes
The pattern remains the same for treatment times in excess of 2 hours.

Only one time-based code may be performed at a time.
If more than one procedure code is billed for the same date of service, then in order to fully support all of the billed services the time must be separately documented for each specific procedure or time-based service. This will clearly document what portion of the total visit was spent performing each of the billed codes.

Methods and examples for time documentation:

Acceptable:
• A specific number of minutes. Example: "Manual therapy to lumbar spine x 15 minutes."
• Listing begin-time and end-time for service. Example: "E-stim to the cervical spine, 09:30 – 09:45."

Unacceptable:
• Documenting time in terms of "units". Examples: "One unit of pulsed ultrasound was administered." or "Ther Ex 1 unit."
• Documenting time using a range. Example: "Therapeutic activities x 6 – 12 minutes as appropriate per assessment and symptoms."
• Documenting a quantity but not specifying the measurement or increment used. Example: "97110 Exercises x 2"
• No time mentioned at all. Example: Checking or circling "NMR" or "TE" with no additional information documented.

For time-based service(s), ensure that the documentation contains the duration (e.g. start and stop times-preferred by the Plan), the issues addressed, and the service provider's signature.

Reporting Units for Timed Codes:

Some CPT codes for modalities are considered experimental, investigational and/or unproven/EIU and are not covered by the Plan. However, some modalities may be eligible for reimbursement, the following information will apply.

When multiple units of therapies or modalities are provided, the 8-minute rule must be followed when billing for these services. A provider should not report a direct treatment service if only one attended modality or therapeutic procedure is provided in a day and the procedure is performed for less than 8 minutes.

- The time reported should be the time actually spent in the delivery of the modality and/or therapeutic procedure. This means that pre- and post-delivery services should not be counted in determining the treatment time.
- The time that the member spends not being treated, due to resting periods or waiting for a piece of equipment to become available, is not considered treatment time.
- All treatment time, including the beginning and ending time of the direct treatment, must be recorded in the member's medical record, along with the note describing the specific modality or procedure.
- Each minute of time may only be counted once. Any actual time the therapist uses to attend one-on-one to a member receiving a supervised modality cannot be counted for any other service provided by the therapist.

Treatment Plan:
3x week for 2 weeks visit 3 of 6
Reduce pain and restore normal ADL
Nourish Kidney Yin, Move Qi & Blood, relieve stagnation and pain.

Acupuncture	Points Inserted/Re-inserted	Face to Face time	Retention time
Set 1	GB 34, GB 41, LV 8	5:20-5:45pm	10 min
Set 2	LV 3, SI 3, SI 8, HT 7	5:55-6:05pm	5 min
Set 3	HT 3, LV 14, Ren 6, Ear SM	6:10-6:30pm	10 min

*Clean Needle Technique (CNT) is used in every treatment.
Face-to-face time includes day-to-day evaluation, hand washing, choosing and cleaning points, inserting and manipulating needles, monitoring, removal, and disposal of needles, and completion of the chart notes with patient present.

Therapy Code/description	Area(s) of application	Time
97140 Manual therapy, myofascial release, and deep tissue mobilization	Lumbar paraspinal and glutes	6:35-6:50

Comments and responses to care: Pt reported pain as minimal post-care and had 100% ROM. Follow up at home with intermittent heat and knee to chest and hamstring stretches

Signature: Date:

Supervised Modalities

- Type and intensity if applicable
- Area(s) applied
- Time of application (timed services 8-minute rule)

Documentation of Infra-Red Heat 97026

Infrared heat applied to lumbar paraspinal musculature for 15 minutes to reduce muscle spasm and improve local circulation. Patient tolerated treatment well with decreased reported tightness post-treatment.

SUPERVISED
The application of a modality that *does not* require direct (one one-on-one) patient contact by the provider.

Application of a modality to one or more areas;

97010	Hot or cold packs	1 unit max
97012	Traction, mechanical	
97014	Electrical stimulation, (unattended)	
G0283	Electrical stimulation, (VA,MC, UHC)	
97016	Vasopneumatic devices	
97018	Paraffin bath	
97022	Whirlpool	
97024	Diathermy (Includes Microwave)	
97026	Infrared	
97028	Ultraviolet	

CONSTANT ATTENDANCE
The application of a modality that requires direct (one on one) patient contact by the provider.

Application of a modality to one or more areas;

97032	Electrical Stimulation (manual), 15 min.
97033	Iontophoresis, each 15 minutes
97034	Contrast baths, each 15 minutes
97035	Ultrasound, each 15 minutes
97036	Hubbard tank, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)

Constant Attendance Modalities

- Type and intensity if applicable
- Area(s) applied
- Time of application (timed services 8-minute rule)

Documentation of Attended Electrical Stimulation 97032

Attended electrical stimulation (97032) provided for 15 minutes utilizing handheld probe stimulation to identified trigger points within bilateral upper trapezius and cervical paraspinal musculature. Direct one-on-one contact maintained throughout treatment. Intensity and probe placement adjusted continuously based on muscle response and patient tolerance. Improved muscle relaxation noted with reduction in palpable spasm. Patient reported pain reduction from 6/10 to 4/10 following treatment.

SUPERVISED
The application of a modality that *does not* require direct (one one-on-one) patient contact by the provider.

Application of a modality to one or more areas;

97010	Hot or cold packs	1 unit max
97012	Traction, mechanical	
97014	Electrical stimulation, (unattended)	
G0283	Electrical stimulation, (VA,MC, UHC)	
97016	Vasopneumatic devices	
97018	Paraffin bath	
97022	Whirlpool	
97024	Diathermy (Includes Microwave)	
97026	Infrared	
97028	Ultraviolet	

CONSTANT ATTENDANCE
The application of a modality that requires direct (one on one) patient contact by the provider.

Application of a modality to one or more areas;

97032	Electrical Stimulation (manual), 15 min.
97033	Iontophoresis, each 15 minutes
97034	Contrast baths, each 15 minutes
97035	Ultrasound, each 15 minutes
97036	Hubbard tank, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)

Procedures

Units based on time

- 15 minutes
- One-On-One with direct contact
- Time of application (timed services 8-minute rule)

97124 Massage

97140 Manual therapy

97110 Therapeutic exercise

97112 Neuromuscular reeducation

97530 Therapeutic activities

THERAPEUTIC PROCEDURES
A manner of effecting change through the application of clinical skills and or services that attempt to improve function.

Physician or therapist required to have direct (one one-on-one) patient contact.

Therapeutic procedure, one or more areas, 15 min.

97110 Therapeutic exercises to develop strength and endurance, range of motion, and flexibility.
97112 Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception.
97113 Aquatic therapy with therapeutic exercises
97116 Gait training (includes stair climbing)
97124 Massage, including effleurage, petrissage, tapotement (stroking, compression, percussion)
97139 Unlisted therapeutic procedure (specify)
97140 Manual therapy techniques, one or more regions.(for example, mobilization, manipulation, manual traction, manual lymphatic drainage)

Additional Procedures

97150 Therapeutic procedure(s), group (2 or more)
97530 Therapeutic activities, direct (one one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 min.

97535 Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, safety procedures, and instructions in use of adaptive equipment) direct one one-on-one contact by provider, each 15 minutes.
97537 Community/work reintegration training (e.g., avocational activities and/or work environment/modification analysis, work task analysis), direct one one-on-one contact by provider, each 15 minutes.

Massage and Manual Therapy

- Tui Na?
- Gua Sha?
- The determining factor is what was actually performed and documented, not what the treatment is called. CPT 97124 describes therapeutic massage techniques including effleurage, petrissage, tapotement, stroking, compression, and percussion, billed in 15-minute increments.

If the **Tui Na** treatment primarily consists of:

- Soft tissue mobilization
- Kneading
- Compression
- Rhythmic stroking
- Percussion techniques
- Therapeutic massage directed to a specific medical condition
- Then it is Massage 97124

Documentation

- **Medical Necessity**
  - Cervical myofascial pain with muscle spasm limiting cervical rotation and driving tolerance.
- **Area Treated**
  - Bilateral cervical paraspinals, upper trapezius, levator scapulae.
- **Technique**
  - Tui Na utilizing kneading, rolling, compression, and percussion techniques directed to affected musculature.
- **Time**
  - 15 minutes direct one-on-one contact.
- **Functional Goal**
  - Reduce muscle spasm and improve cervical rotation to allow safe driving and work activities.
- **Response**
  - Decreased muscle tension and improved cervical rotation following treatment.

If the **Tui Na** treatment primarily consists of:

- Myofascial release
- Fascial mobilization
- Trigger point release

Gua Sha

- Gua Sha (instrument-assisted scraping of soft tissues) is often best described as:
- Soft tissue mobilization
- Myofascial mobilization
- Connective tissue mobilization
- Instrument-assisted soft tissue mobilization
- Gua Sha is typically intended to mobilize fascia, connective tissue, and soft tissue restrictions rather than provide therapeutic massage.
- Then it is manual therapy 97140

Documentation

- Manual therapy (97140) performed for 15 minutes utilizing instrument-assisted soft tissue mobilization (Gua Sha) to the bilateral upper trapezius, levator scapulae, and cervical paraspinal musculature. Treatment directed toward reducing myofascial restriction, improving tissue mobility, decreasing pain, and increasing cervical range of motion. Direct one-on-one contact maintained throughout treatment. Patient demonstrated improved tissue mobility and decreased tenderness following treatment.

Avoid documenting simply:

- "Gua Sha / Tuina performed for 15 minutes."

Common Audit Risks for 97124 & 97140

Avoid

- "Massage performed.“
- "Massage x 15 minutes.“
- "Patient tolerated well."

Instead

1. Why the massage was medically necessary.
2. The specific anatomical areas treated.
3. The massage techniques used.
4. One-on-one timed minutes.
5. Objective findings before treatment.
6. The patient's response and functional relevance.

97124

- Purpose
  - ❑ Reduce muscle spasm
  - ❑ Decrease pain
  - ❑ Improve circulation
  - ❑ Reduce soft tissue restrictions
  - ❑ Decrease edema
  - ❑ Improve tissue mobility
  - ❑ Increase functional movement
  - ❑ Other
- Body Region(s) Treated
  - ❑
- Techniques performed
  - ❑ Effleurage
  - ❑ Petrissage
  - ❑ Compression
  - ❑ Friction Massage
  - ❑ Percussion/Tapotement
  - ❑ Other
- One on One Time
- Start Time _____
- End Time _____
- Patient Tolerance & Response

☐ Well ☐ Fairly Well ☐ Discomfort

- **97110 Therapeutic Exercises are movements and physical activities designed to restore function and flexibility, improve strength and decrease pain**

- Includes instruction, feedback, and supervision of a person in an exercise program for their condition. The purpose is to increase/maintain flexibility and muscle strength. May be performed with a patient either actively, active-assisted, or passively.
- Improve impairments (weakness, limited ROM, poor endurance, reduced flexibility)
  - Heel raises
  - Straight-leg raises
  - Theraband resistance
  - Wall slides
  - Prone extensions
  - Treadmill walking (if only for endurance)

Objective:
Improve lumbar stability and hip strength to increase tolerance for standing > 20 minutes.

Interventions Performed:

- Core stabilization progression: abdominal bracing with alternating leg extensions, 2×10 reps.
- Hip abduction strengthening: Theraband level 2 resistance, 2×12 reps.
- Lumbar ROM drills: controlled flexion/extension in pain-free range, 10 repetitions.

- Time one-on-one 15 minutes
- **Provider Involvement:**
  Provided verbal and tactile cues for proper alignment, breathing technique, and controlled movement to prevent compensatory lumbar rotation.
- **Patient Response:**
  Demonstrated improved core activation and tolerance to exercises with reduced low-back discomfort.
- **Plan:**
  Progress resistance and repetitions as tolerated to further improve lumbar endurance.

97530 Therapeutic Activities

The CPT definition of 97530 is “Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes.”

Purpose:

- Dynamic, functional activities designed to improve the patient's ability to perform everyday movements or tasks.
- Treatment involves using multiple muscle groups together
- The activity is tied to real-world functional goals (lifting, pushing, pulling, bending, transitions, reaching, carrying, etc.)
- Therapist is teaching/modifying a functional movement pattern, not an isolated exercise

97530

When to use:

- Treatment involves using multiple muscle groups together
- The activity is tied to real-world functional goals (lifting, pushing, pulling, bending, transitions, reaching, carrying, etc.)
- Therapist is teaching/modifying a functional movement pattern, not an isolated exercise

Examples:

- Lifting a box from floor to shelf
- Sit-to-stand training
- Reaching tasks simulating ADLs
- Pushing/pulling objects to improve work tasks
- Gait-related obstacle tasks
- Functional squatting or bending to mimic job or home activities

97530 Documentation must include:

- The specific *functional* activity performed
- The functional purpose (e.g., “improve ability to lift 10 lbs at work”)
- How the provider guided, cued, or modified the activity
- Time spent (must support 15 minutes of one-on-one care per unit)

Objective:
Improve ability to lift 10–15 lb objects at work with correct body mechanics to reduce low-back strain.

Functional Tasks Performed:

- Floor-to-waist box lift training: using a 10-lb weighted box. Practiced 8 repetitions emphasizing hip hinge and neutral spine.
- Reach-and-place activity: lifted box from waist height to overhead shelf, 6 repetitions.
- Simulated work-task transitions: forward-reach with controlled squat and return, 8 repetitions.

- **Provider Involvement:**
  Patient direct supervision 20 minutes - constant verbal and tactile cues on hip hinge strategy, spinal alignment, controlled eccentric movement, and proper grip/lift technique.
- **Patient Response:**
  Improved lifting mechanics with reduced lumbar flexion compensation; tolerated all tasks without increased pain.
- **Plan:**
  Increase box weight to 12–15 lbs next visit and progress to more complex work-simulation tasks.

- Choosing 97530 or 97110 depends on the intent of the task. For example, abdominal curls can be used for strengthening weak abdominal muscles and is considered exercise 97110
- However, if the patient is incorporating abdominal curs with other movements to facilitate rising from a lying position, it would be considered a therapeutic activity.
- Best practice is to determine what functional outcome is expected from the task. Is it simply a strength or flexibility outcome, or one with a functional performance outcome?
- **97110** note focuses on **exercise**, reps/sets/resistance, and impairments (strength, ROM).
- **97530** note focuses on **functional tasks** that simulate real-life movement (lifting, reaching, transitions).
- Both include objective purpose, provider involvement, patient response, and time. The items auditors look for.

Audit Note

If documentation does **not** clearly state a functional purpose (“to improve ability to lift, carry, transfer, reach, bend, etc.”), 97530 is usually denied.

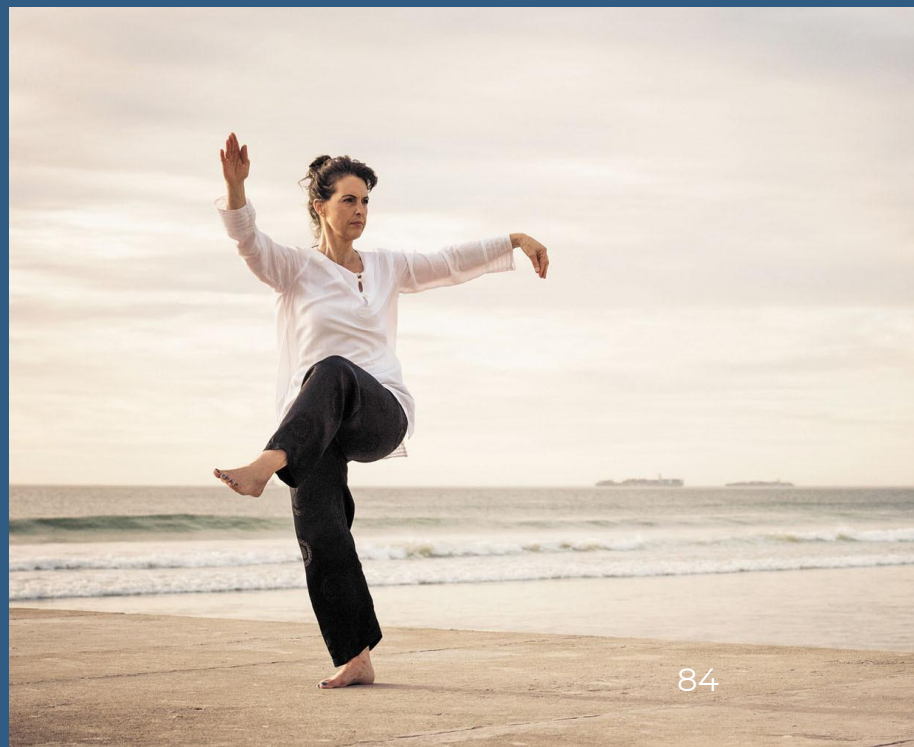
If the service is **an exercise**, payers will default to **97110**, not 97530.

97530 typically reimburses higher, so insurers scrutinize it more closely.

97112 Neuromuscular Re-education

- Balance
- Coordination
- Kinesthetic sense
- Posture Proprioception
- Motor control Movement patterns

- Tai Chi?
- Postural control
- Balance
- Fall prevention
- Weight shifting
- Coordination
- Neuromuscular control



CPT 97112

- Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities, each 15 minutes

- Time –based skilled therapeutic procedure that involves direct one-on-one contact with the patient to improve neuromuscular control and functional movement patterns.
- It is **not just exercise**, it specifically targets how the nervous system coordinates muscle activity, posture, and movement.

recovery or require prolonged treatment beyond the natural history of recovery. The natural history of recovery is the anticipated recovery either with conservative treatment/care or without conservative treatment/care. The lack of continued functional improvement with continued treatment and complicating factors indicates a stable condition. Although the patient's condition may continue to change over time, the continuation of treatment is no longer necessary in order to affect those further changes. Furthermore, according to the evidence-based literature, the continuation of treatment after a patient has stabilized promotes patient/treatment dependence and feelings of unresolvable disability and may delay a return to normal function. The scientific literature supports a therapeutic withdrawal after the patient has stabilized which focuses more on home-based stretches and exercises and promotes a more active role of the patient.

CPT code 97112 is intended to identify therapeutic exercise that is used for the treatment of upper motor neuron lesions (i.e. stroke, paralysis). Neuromuscular re-education may also be considered medically necessary if at least one of the following conditions is present and documented: the patient has the loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers; the patient has nerve palsy, such as peroneal nerve injury causing foot drop; or the patient has muscular weakness or flaccidity as a result of a cerebral dysfunction, a nerve injury or disease, or has had a spinal cord disease or trauma. According the records provided for review, the patient did not exhibit any of the necessary signs or symptoms needed in order to initiate this type of therapy. Therefore, the dates of service in question are not medically necessary in relation to the motor vehicle accident.

In conclusion, I do not recommend reimbursement for treatment rendered on 02/14/19, 03/05/19 or 04/01/19

97112

- **Duration:** 15 minutes, one-on-one
- **Interventions:**
  - Single-leg stance balance on foam pad (3×20 sec)
  - Eccentric heel raises with tactile cueing (2×10)
  - Step-down retraining emphasizing proprioceptive control
- **Purpose:** Facilitate proprioceptive input, improve ankle stability, and restore coordinated lower-extremity movement patterns following pain reduction.
- **Response:** Improved postural control, decreased compensatory trunk sway. Demonstrated better motor sequencing and stability post-session.

- **A patient has:**
  - Chronic balance deficits
  - History of falls
  - Impaired proprioception

The provider spends 15 minutes providing one-on-one instruction and correction utilizing Tai Chi weight-shifting exercises to improve balance and reduce fall risk.

Neuromuscular reeducation (97112) performed for 15 minutes utilizing Tai Chi-based balance and weight-shifting exercises. Direct one-on-one instruction provided to improve postural control, proprioception, coordination, and fall-prevention strategies. Verbal and tactile cueing provided throughout treatment to correct movement patterns and improve dynamic balance. Patient demonstrated improved weight transfer and stability during gait activities.

Medical Necessity

- Are the goals being accomplished?
- Is the patient getting better?

Extent Of Meaningful Improvement

- Significant durable pain intensity decrease
- Functional improvement by clinically meaningful improvement on validated disease-specific outcomes instruments; return to work; and/or documented improvement in activities of daily living
- Documented decreased utilization of pain-related medications
- Objective measures demonstrating the extent of meaningful clinical improvement today and the rational for additional treatment requested example to reach further durable improvement or for ongoing pain management and any further information supporting the need for additional care
- Include any barriers to recovery such as complicating conditions or comorbidities but also how the patient has changed to date and how the care would continue the same trajectory

PROMIS
Patient Reported Outcome Measurement Instruments

- General Pain Index
- Patient Specific Functional Scale
- PROMIS Short Form – Pain Interference
- Pain and Functional Rating Scale (VA & DOD)
- Oswestry (LBP index)
- Neck Disability Index

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____ DATE _____

SCORE _____ [60] BENCHMARK = 5 _____

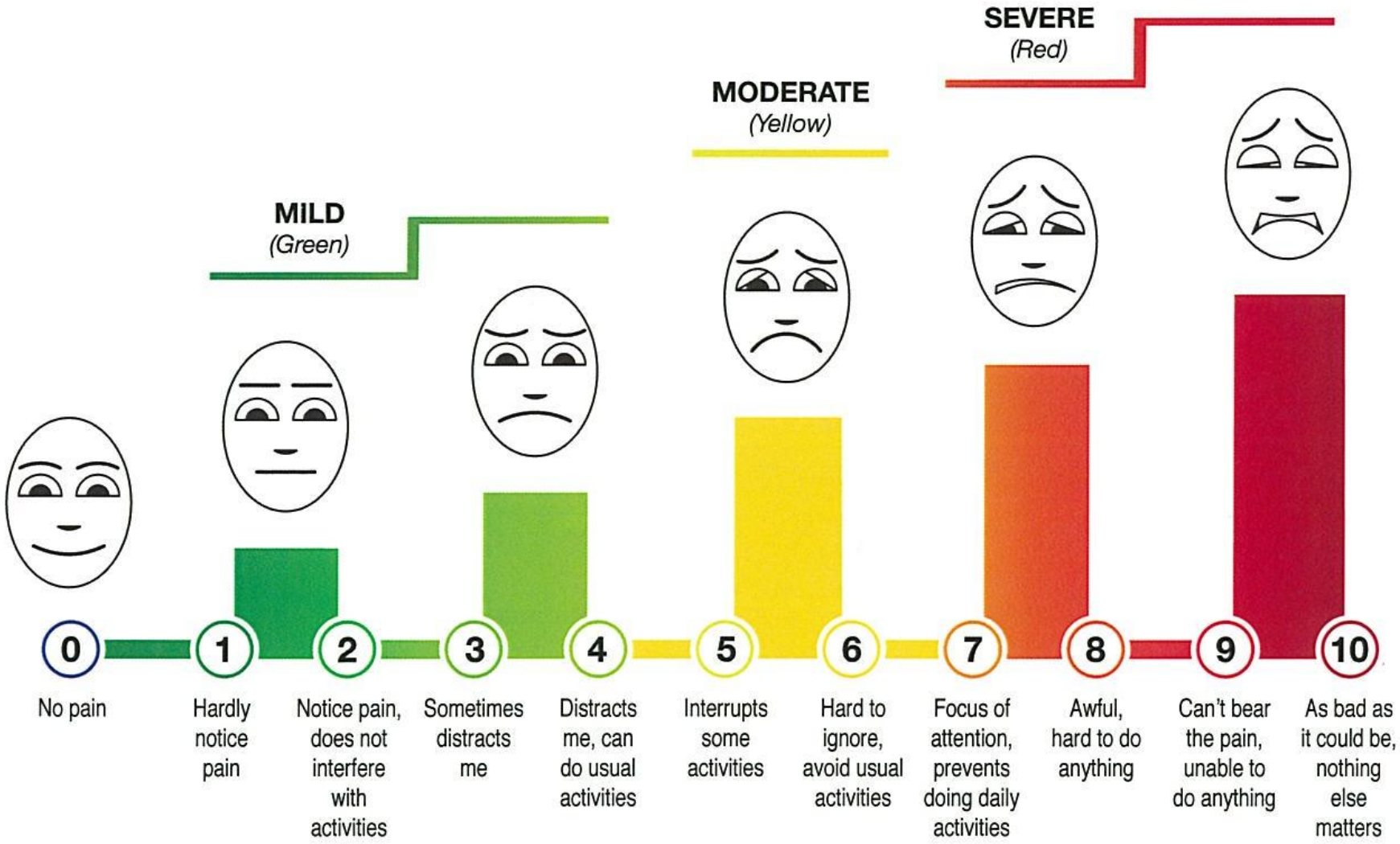
Pain Interference – Short Form 6a

Please respond to each question or statement by marking one box per row.

In the past 7 days…

		Not at all	A little bit	Somewhat	Quite a bit	Very much
1	How much did pain interfere with your day to day activities?	☐	☐	☐	☐	☐
2	How much did pain interfere with work around the home?.....	☐	☐	☐	☐	☐
3	How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
4	How much did pain interfere with your household chores?.....	☐	☐	☐	☐	☐
5	How much did pain interfere with the things you usually do for fun?	☐	☐	☐	☐	☐
6	How much did pain interfere with your enjoyment of social activities?.....	☐	☐	☐	☐	☐

Defense and Veterans Pain Rating Scale



What About?

- I am a cash-based practice and do not bill or participate with insurance.
- I am a high-volume practice
- I do community-based acupuncture

The Key Lesson For Compliance

- In high-volume practices, documentation is the only evidence of individualized care.
- Good documentation does not require long notes.
- It requires consistent, intentional elements.

What to Avoid (High-Risk)

- **Red Flags –Board & Plaintiff Triggers**
- Identical notes visit after visit
- No subjective variation ever documented
- No reassessment over time
- Retroactive or batch documentation
- “Acupuncture Performed” only

Although cash-based practice notes are not required for billing, I recommend documenting:

- Chief complaint
- Pain level or functional complaint
- Areas treated
- Number of needles and placement
- Adjunctive therapies
- Patient response

Initial Visit

- **Patient Information**
  - Name
  - DOB
  - Contact information
- **Health History**
  - Chief complaint(s)
  - Relevant health history
  - Medications
  - Allergies
  - Contraindications

- **Assessment**
  - A brief assessment may include:
  - Pain area(s)
  - Severity
  - Duration
  - Relevant findings
- **Treatment Plan**
- **Informed Consent**
- **Treatment**

Acupuncture performed to lumbar and lower extremity points. 14 needles inserted (indicate points) and removed without complication. Infrared heat applied to lumbar region for 15 minutes.

Patient tolerated treatment well and reported decreased tightness following treatment.

Cash Practice Note

S: Neck pain 5/10, improved since last visit.

O: Cervical muscle tension and tenderness noted.

A: Continued improvement.

P: Acupuncture performed to cervical and upper thoracic regions. 12 needles (indicate points) inserted and removed without incident. Patient tolerated treatment well.

Sam’s 5 - Quick Audit

1. Why was the patient there?
2. What condition was treated?
3. What treatment was performed?
4. Were needles removed?
5. How did the patient respond?

If those five questions are answered, the documentation is usually adequate for a cash-only acupuncture practice from a clinical and risk-management perspective.

- Even cash-only providers should maintain records that are legible, contemporaneous, and complete enough to support continuity of care. If a patient later requests records for reimbursement from a health plan, workers' compensation case, personal injury claim, HSA/FSA substantiation, or legal matter, sparse records can become a problem.

- Therefore, while insurance-level documentation is unnecessary, I generally recommend a streamlined SOAP note with treatment details and patient response rather than a treatment log alone.

Documentation Protects More Than Payment

- Documentation protects the provider and the patient
- It is not about billing
  - It is about defensibility
  - It is about professional credibility

Minimal documentation is acceptable.

Missing documentation is not.

Smart, consistent notes protect the provider, the patient, and the brand.