Medicare Documentation Requirements Explained

The documentation requirements for an initial and a subsequent visit may vary from one payor to the next and should be followed per the Medical Review Policy of that payor. In the absence of any other guidelines, use the Medicare guidelines. Medicare's documentation requirements aid in proving medical necessity. These standards are published in most Chiropractic Local Coverage Determinations (LCDs) or Local Coverage Articles (LCAs) from your Medicare Administrative Contractor (MAC). Just as no two patients are the same, documentation varies, too—it must be appropriate for the conditions being treated. This tool strives to clarify the stated requirements.

Initial Visit

Initial visit notes tend to be more robust than daily routine office visits or SOAP notes. An Evaluation and Management (E/M) service is documented in an initial visit and lays the groundwork for the entire course of treatment. An initial visit is any visit that kicks off a new episode of care, whether for a new or returning patient. **Note:** This can include an existing patient presenting with a new condition, an exacerbation, or a new injury.

Medicare's Stated Requirement	What It Means
A **detailed patient history** that includes: • Symptoms that caused the patient to seek treatment and when the problem started • Description/mechanism of the current injury • Quality, character, frequency, and location of the symptoms • His/her relevant family history and past health history	• Each initial visit, whether a new patient or new episode of active care, must include necessary history components of the E/M service, beyond simple "subjective" • Identification of specific functional activities that are affected by the condition, including measurable deficits in Activities of Daily Living (ADLs). • With multiple complaints, outline each complaint with details as noted • The initial visit documentation clearly forms the baseline, foundational visit for the episode of care, detailing why the patient is seeking care • There is a clear mechanism of injury, or comments regarding when the condition started. If no clear injury has occurred, rule out accidents, slips, trips and falls and indicate when the pain started. • Update any changes in family and health history, and social history or habits on returning patients, as appropriate
An **evaluation** of the musculoskeletal & nervous system determined through a physical exam	• The components of PART should be present for all spinal regions in which there is a complaint. If using x-ray to identify the subluxation, include the findings and date of the study. • Appropriate orthopedic and neurological test performed to quantify the complaints and justify the diagnosis • Specific segments for primary areas to be treated are clearly indicated • Secondary compensations, or asymptomatic findings are clearly indicated • Include additional body systems or areas that may be affecting, or be affected by, the presenting problem.
A **diagnosis** (**Note:** the primary diagnosis for Medicare must be subluxation) that includes a stated level or that is identified by a term descriptive of subluxation.	• The medical record contains written diagnoses for each condition/region to be addressed, with or without ICD-10 codes • Diagnoses are "coupled" per the Medicare rules, with primary as subluxation (segmental dysfunction) and secondary as the neuromusculoskeletal diagnosis, listed for each spinal region.
A **plan for treatment** including recommended level of care (duration and frequency of visits); the specific functional treatment goals related to the impacted activities of daily living; and objective measures to evaluate the effectiveness of the treatment.	• Include the expected duration in days/weeks/month for this active episode of care • Indicate the frequency of visits up to the first re-evaluation or discharge if the episode is expected last less than a month. • List short-term and long-term goals related to the functional deficits collected in the history section of the note. Ensure they can be easily measured on a visit-to-visit basis. • Indicate what effectiveness measure you plan to use to determine whether the treatment is working. Often, Outcomes Assessment Tools (OATs) are used, and the initial score is recorded with a goal score. This is easily measured at re-evaluation intervals.

Subsequent Visits

Also known as routine office visits (ROV) this style describes the treatment visits where the patient is being seen for the execution of the written treatment plan from the beginning of the Episode of Care. Medicare's documentation requirements outline the necessary elements for ROV to meet the medical necessity guidelines. Daily visit or ROV visit notes must tell the patient's story from visit to visit. They should show the patient's progression to help prove that medical necessity of treatment still exists. These visits are typically expressed in the SOAP format. **Note:** Include the ROV number within the episode, such as Visit 3 of a planned 12.

Medicare's Stated Requirement	What It Means
(S) Review of Chief Complaint (and additional complaints)	• A review of each complaint and notes about changes that have taken place since the last visit. • A focus on the stated functional goals from the treatment plan and comments (often in the patient's own words) about their level of function related to the goals. • A pain rating (0-10) is appropriate for each complaint, but not required
(S) History	• This requirement is rooted in the patient's subjective report on the visit. Include the items noted above and list new concerns or complaints that do not warrant a new episode of care.
(O) Physical Examination (PART)	• An objective, physical assessment that addresses the area(s) of the spine involved in the diagnosis and plan. Although a reiteration of the elements of PART are not required on a visit-to-visit basis, these components are easily measured as objective findings. • Note changes in objective findings since the last recorded visit. • List observation of the presence or absence of a subluxation (using PART) using appropriate terminology such as spinal restrictions • Note primary subluxation findings as well as any asymptomatic, compensatory segment findings that will be addressed
(A) Assessment	• Assessment elements are the result of what was learned in the subjective and objective portions of the visit. • The provider's assessment and description of progress (or lack thereof) related to treatment goals and care plans. This is where the expression of the provider's "thinking" is included in the ROV note. • Include information on HOW the patient is (or isn't) improving. Be specific, even if reiterating what was reported by the patient related to their functional goals. • Include information on WHY the patient does or doesn't need more care. Provide reasoning here if the decision is made to alter treatment or frequency. • Elaborate on changes due to exacerbation and how the original plan will be affected, if at all.
(P) Documentation of Daily Treatment	• This is where the treatment listed in the original plan is executed. While every service planned for may not be performed each visit, this is where the services are outlined, and from which treatment codes are obtained. • For Chiropractic Manipulative Treatment (CMT), list each segment adjusted, separating primary spinal regions from asymptomatic, secondary compensations being addressed, but not billed. • Document time spent for all modalities and procedures, and for treatments that are time-based for coding, include both individual and total billable time. • Home care recommendations should be noted, including instructions for the use of ice, heat, exercises, etc. • Comments about the response to that day's treatment can be included here