Medicare Documentation Job Aid for Chiropractic Doctors

What's Changed?

No substantive content updates.

Introduction

Has a Medicare contractor sent you a request for documentation, but you aren't sure your records comply? This job aid is designed to help you (chiropractic doctors) respond to documentation requests.

Documentation Guidance

Documentation guidance includes, but is not limited to:

Patient Information

- ☐ Include the patient's name and date of service on all documentation

Subluxation

- ☐ Include documentation of subluxation demonstrated by x-ray, date of x-ray: _____
  - o Include a CT scan and or MRI demonstrating subluxation of spine.
  - o Include documentation of your review of the x-ray, MRI, or CT, noting level of subluxation.
  - o Include x-rays taken within 12 months before or 3 months following the beginning of treatment. In certain cases of chronic subluxation (for example, scoliosis), Medicare may accept an older x-ray if the patient's health record indicates the condition existed longer than 12 months and it is reasonable to conclude the condition is permanent.

Or

- ☐ Include documentation of subluxation demonstrated by physical examination. Documentation must show at least 2 elements of Pain, Asymmetry/misalignment, Range of motion abnormality, Tissue tone changes (P.A.R.T.), including 1 that falls under Asymmetry/misalignment or Range of motion abnormality.
  - ☐ Include dated documentation of initial evaluation
  - ☐ Include primary diagnosis of subluxation (including level of subluxation)
- ☐ Include documentation of presence or absence of subluxation for every visit
- ☐ Include any documentation supporting medical necessity

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Task Force for Error-Free Medicare Claims

Initial Evaluation

- ☐ History
  - ☐ Date of initial treatment
  - ☐ Description of current illness
  - ☐ Symptoms directly related to level of subluxation causing patient to seek treatment
  - ☐ Family history, if relevant (recommended)
  - ☐ Past health history (recommended)
  - ☐ Mechanism of trauma (recommended)
  - ☐ Quality and character of symptoms or problem (recommended)
  - ☐ Onset, duration, intensity, frequency, location, and radiation of symptoms (recommended)
  - ☐ Aggravating or relieving factors (recommended)
  - ☐ Prior interventions, treatments, medication, and secondary complaints (recommended)
- ☐ Contraindications (for example, risk of injury to patient from dynamic thrust or discussion of risk with patient) (recommended)
- ☐ Physical examination (P.A.R.T.)
  - ☐ Evaluation of musculoskeletal and nervous system through physical examination
- ☐ Documentation of presence or absence of subluxation for every visit
- ☐ Treatment given on day of visit (if applicable)
  - o Include specific areas and levels of the spine where manipulation was performed.
  - o Medicare may cover treatment performed using hand-held devices; however, Medicare does not offer additional payment or recognize an extra charge for use of the device.

Treatment Plan

- ☐ Frequency and duration of visits (recommended)
- ☐ Specific treatment goals (recommended)
- ☐ Objective measures to evaluate treatment effectiveness (recommended)

Subsequent Visit

- ☐ History
  - ☐ Review of chief complaint
  - ☐ Changes since last visit
  - ☐ System review, if relevant
- ☐ Physical examination (P.A.R.T.)
  - ☐ Assessment of change in patient condition since last visit
  - ☐ Evaluation of treatment effectiveness
- ☐ Documentation of presence or absence of subluxation for every visit
- ☐ Treatment given on day of visit (include specific areas and levels of spine where manipulation was performed)

General Guidelines

- ☐ Make sure medical records submitted show that the service is a corrective treatment, rather than maintenance
  - o For Medicare purposes, place an AT modifier on a claim when you provide active or corrective treatment to treat acute or chronic subluxation
    - Do not use Modifier AT when you perform maintenance therapy
    - Only use modifier AT when chiropractic manipulation is reasonable and necessary as defined by national and local policy
    - **Note:** Presence of the AT modifier may not indicate the service is reasonable and necessary. As always, contractors may deny after medical review.

    Make sure you know these policies, along with any local coverage determination in your area, to better understand how active or corrective chiropractic services are covered.
- ☐ Submit records for all dates of service on a claim
- ☐ Make sure documentation is legible and complete, including signatures
- ☐ Include legible signatures and credentials of professionals providing services
  - o If signatures are missing or illegible, include a completed signature attestation statement.
  - o For illegible signatures, include a signature log.
  - o For electronic health records, include a copy of electronic signature policy and procedures describing how notes and orders are signed and dated. Validating electronic signatures depends on obtaining this information.
- ☐ Include abbreviation key (if applicable)
- ☐ Include any other documentation to support medical necessity of services billed, as well as documentation specifically requested in an additional documentation request (ADR) letter
- ☐ Include a copy of the Advance Beneficiary Notice of Noncoverage (if applicable)

Resources

- Comprehensive Error Rate Testing (CERT)
- Medicare Benefit Policy Manual, Chapter 15, Sections 30.5 and 240
- Medicare Claims Processing Manual, Chapter 12, Section 220
- MLN Matters® SE1601 Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits
- MLN Matters® SE1603 Educational Resources to Assist Chiropractors with Medicare Billing
- Medicare.gov

CERT Disclaimer

The Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) Medicare Administrative Contractor (MAC) Outreach & Education Task Force developed this document to provide nationally consistent education on topics of interest to health care professionals. The CERT A/B MAC Outreach & Education Task Force is independent from the CMS CERT team and CERT contractors, which are responsible for calculation of the Medicare Fee-for-Service improper payment rate. Visit the CMS CERT webpage to learn about the CERT Program and review CERT Improper Payments Reports.